Supreme Court, U.S.
FILED
07-331 SEP 7 - 2007
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No. 07-___

In The

Supreme Court of the United States

SUN LIFE ASSURANCE COMPANY OF CANADA,

Petitioner,

v.

MARGARET T. WHITE,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Fourth Circuit erred in holding, contrary to five other circuits, that an unambiguous limitations period contained in an ERISA-governed disability insurance policy was *per se* unenforceable solely because the policy required the limitations period to begin when proof of claim was due under the policy rather than when the benefit claim was denied, where the limitations period allowed Respondent more than 28 months to file suit after her benefit claim was denied, and where the policy language was mandated by state insurance laws in North Carolina and forty-eight other states.

PARTIES TO THE PROCEEDING

Margaret T. White was the plaintiff in the district court and the appellee in the Fourth Circuit. Sun Life Assurance Company of Canada ("Sun Life") was the defendant in the district court and the appellant in the Fourth Circuit. Other parties who were originally named as additional defendants in the district court are no longer parties to this proceeding, having been dismissed by the district court.

CORPORATE DISCLOSURE STATEMENT

Sun Life Assurance Company of Canada is a wholly owned subsidiary of Sun Life Financial Inc., a publicly traded company. No publicly traded entity owns 10% or more of the stock of Sun Life Financial Inc.

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PETITION FOR WRIT OF CERTIORARI

Life, health, and disability benefit plans governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.* ("ERISA") are frequently funded by insurance. *See, e.g.,* 29 U.S.C. §1002(1) (defining an employee welfare benefit plan as being funded "through the purchase of insurance or otherwise"). Insurance laws in forty-nine states require life, health, and disability insurance policies to include, among other provisions, a limitations period that accrues at the time proof of claim is due under the policy. There is nothing in ERISA that forbids a proof of claim accrual clause. In fact, ERISA does not even specify a limitations period applicable to suits for denied benefits, leaving these and other plan provisions to the discretion of plan drafters. *See generally Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003) ("employers have large leeway to design . . . plans as they see fit").

Prior to 2007, published decisions by the Fifth, Seventh, and Eighth Circuits, and unpublished decisions by the Sixth and Tenth Circuits, enforced insurance policy proof of claim accrual clauses in ERISA benefit suits. Only the Ninth Circuit refused to do so. Now the Fourth Circuit has joined the minority view. Combined with a Third Circuit decision issued earlier in 2007, there are now three circuits that have virtually erased universal, mandatory, and unambiguous language from hundreds of policies that fund ERISA plans across the United States, not because of any prohibition in the ERISA statute, but based upon perceived policies of ERISA. Even worse, the three circuits that rejected proof of claim accrual provisions adopted different "default" accrual rules, leaving ERISA plans and their insurers subject to varying rules that are not only

inconsistent with the unambiguous terms of the plans, but are also inconsistent with each other.

The matter is ripe for review. First, with two circuits joining the minority position, there is now a broad split in the circuits. Second, national ERISA plans that are supposed to be subject to uniform federal regulation, are now subject to inconsistent application of identical plan terms, depending upon where lawsuits are filed. Third, the reasoning of the Fourth Circuit and similar decisions causes other ERISA plan terms to be subject to challenge based on contentions that the plan terms are somehow in "tension" with perceived policies of ERISA, even when the terms are clear and unambiguous and there is no statutory provision governing the terms. Finally, this Court's decision in *Order of United Commercial Travelers v. Wolfe,* 331 U.S. 586 (1947), which gave effect to parties' freedom of contract by holding that a contractual limitations period is enforceable where it provides a reasonable time to file suit, is rejected, apparently on the ground that ERISA plan drafters do not share the same contractual freedom. In the end, ERISA plans and their insurers are caught in the middle – on the one hand, state insurance laws forbid insurers from issuing insurance policies that exclude state mandated language and, on the other hand, insurers are *per se* prohibited from enforcing the very same language. The question of when a contractual limitations period begins has broad application to ERISA life, health, and disability plans, their administrators and insurers, as well as non-ERISA entities such as state insurance regulators.

The facts of this case provide a prime vehicle for review of the legal issue. It is undisputed that the policy clause was unambiguous. It is undisputed that, as applied to the facts in this case, the limitations period allowed

Respondent, who was represented by counsel, more than reasonable time (over 28 months) to file suit after her benefit claim was denied. It would be difficult to have a more appropriate factual scenario for resolution of the question presented. Petitioner respectfully requests that the Court grant the writ and overturn the Fourth Circuit decision.

OPINIONS AND ORDERS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, filed on April 26, 2007, is reported at 488 F.3d 240, and is reproduced at Appendix ("App.") 1-47. The Fourth Circuit denied a petition for rehearing *en banc* on June 11, 2007, which decision is unreported and is reproduced at App. 77-78. The decisions of the trial court are reproduced at App. 48-57 (Memorandum and Order dated August 11, 2005); App. 58-73 (Memorandum and Recommendation dated January 7, 2005); and App. 74-76 (Order Clarifying and Amending Memorandum and Order dated September 9, 2005).

JURISDICTION

Respondent filed suit in state court as a result of Sun Life's decision to deny her claim for disability benefits under an ERISA plan. Petitioner and other defendants jointly removed the case to federal court based on ERISA, 29 U.S.C. §1132(e)(1). Petitioner appealed to the Fourth Circuit following an adverse judgment in the district court, pursuant to 28 U.S.C. §1291. The Fourth Circuit affirmed the district court on April 26, 2007. Petitioner sought

rehearing *en banc,* which was denied on June 11, 2007. This Petition is being filed within the ninety-day period following entry of that order pursuant to Sup.Ct.R. 13.1 and 13.3. Petitioner invokes the jurisdiction of this Court under 28 U.S.C. §1254(1).

STATUTES INVOLVED

This case involves section 502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B) and North Carolina General Statutes §58-51-15. The text of these statutes is set out in App. 79 and 80-97, respectively.

STATEMENT OF THE CASE

Factual Background. Respondent was a participant in an ERISA-governed disability plan sponsored by her employer. Benefits were funded by a group disability insurance policy ("Policy") issued by Petitioner. Like most policies of its kind, the Policy included a limitations period as follows:

> No legal action may start . . . more than 3 years after the time Proof of Claim is required.

The Policy was issued in North Carolina in a form approved by the North Carolina Department of Insurance. The limitations period language, including the accrual clause, was mandated for inclusion in the Policy by North Carolina General Statutes §58-51-15:

> (a) Required Provisions – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person

> in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. . . .
>
> (11) A provision in the substance of the following language:
>
> LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. *No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.*

App. 80, 87-88 (emphasis added).

The Policy required that Proof of Claim be submitted "no later than 90 days after the end of the Elimination Period." The "Elimination Period" was 90 days and was defined as "a period of continuous days of Total or Partial Disability for which no LTD [Long Term Disability] Benefit is payable." The Elimination Period "begins on the first day of Total or Partial Disability."

Respondent alleged in her Complaint that her "first day of Total Disability" under the Policy was February 11, 2000. Respondent's Elimination Period expired 90 days later, on May 11, 2000. Her Proof of Claim was due 90 days thereafter, or August 9, 2000. The Policy limitations period expired three years later, on August 9, 2003.

Respondent filed her claim for disability benefits with Petitioner. Following review and an administrative appeal, Petitioner's final notice of denial was sent to Respondent's counsel on March 28, 2001. Respondent had over 28

months – until August 9, 2003 – to file a lawsuit. In May 2002, more than a year after the final claim denial, Respondent's counsel attempted to submit additional information. On May 29, 2002, Petitioner advised in writing that administrative remedies had been previously exhausted and that there would be no further review of the claim. Respondent still had over 14 months to file suit. Respondent did not file suit until March 26, 2004, more than seven months after the Policy limitations period expired.

Proceedings Below. After Respondent's Complaint was removed to federal court under ERISA, Petitioner filed a motion to dismiss on the following grounds: (1) Respondent's state law claims were preempted by ERISA; and (2) Respondent's ERISA claim for benefits was barred by the limitations period in the Policy.

On January 7, 2005, United States Magistrate Judge Dennis Howell of the United States District Court for the Western District of North Carolina entered a Memorandum and Recommendation, converting Petitioner's motion to dismiss into a motion for judgment on the pleadings and granting the motion, ruling that (1) Respondent's state law claims were preempted by ERISA; and (2) Respondent's ERISA claim for benefits was untimely because she did not file this action within the limitations period mandated by the Plan.

Respondent filed objections to the Magistrate's Memorandum and Recommendation. By Order dated August 11, 2005, United States District Judge Lacy H. Thornburg rejected the recommendation of Magistrate Howell regarding the limitations period issue. The district court ruled

that the accrual clause in the Policy was not enforceable as a matter of law.[1]

On September 12, 2005, the parties filed cross-motions for summary judgment on Respondent's claim for benefits under ERISA, 29 U.S.C. §1132(a)(1)(B).[2] On January 31, 2006, the district court awarded Respondent past due benefits, attorney fees, and costs. Petitioner appealed. On April 26, 2007, in a 2-1 decision, the Fourth Circuit affirmed the district court. Addressing the limitations period issue, the majority conceded that the ERISA statute contains no limitations period applicable to benefit suits and agreed that ERISA plans, like other contracts, may incorporate a limitations period if the period is reasonable. The majority also agreed that the limitations clause in the Policy was unambiguous and that the time remaining for Respondent to file suit after her claim was denied (more than 28 months) was reasonable. However, the majority held that unambiguous ERISA plan language requiring the contractual limitations period to begin on the date a claimant's proof of claim was due was *per se* unenforceable. The majority concluded that parties to an ERISA plan may not alter the federal default rule that a limitations period begins when the claim is denied. The majority stated that the plan's limitations period provided an unacceptable level of uncertainty because starting a limitations period before a claim is denied would allow

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[1] On September 9, 2005, the district court clarified its previous Order by expressly adopting Magistrate Howell's recommendation that Respondent's state law claims were preempted by ERISA.

[2] ERISA, 29 U.S.C. §1132(a)(1)(B) provides in part that an employee benefit plan participant may sue to recover "benefits due to him under the terms of his plan."

unscrupulous ERISA claim administrators to delay claim decisions in order to compress the limitations period and because courts would be required to determine in each case whether the remaining period was reasonable.

A lengthy dissent concluded that the limitations period was "eminently reasonable" because it provided Respondent more than sufficient time to file her lawsuit, that the Policy language was "the very one that North Carolina and the vast majority of other states require be included in insurance policies like the one at issue here," and that no controlling law prohibits adoption of the limitations period specified in the Policy. He observed that absent a law preventing a limitations period shorter than the default period, this Court's precedent requires that the contractual periods be enforced so long as they are reasonable. *See Order of United Commercial Travelers v. Wolfe,* 331 U.S. 586, 608 (1947). He observed that tying the limitations period to the date that proof of claim was due has the perfectly rational purpose of ensuring that no suit is too remote in time from the events giving rise to the claim.

The dissent also rejected the majority's conclusion that federal common law can override the unambiguous terms of an ERISA plan. He explained that the three-year period was well designed to leave a claimant with ample time to decide whether to file suit. ERISA claim regulations allow a claim administrator no more than 195 days to decide a claim, including any administrative appeal, thereby eliminating "any significant possibility that a devious plan administrator could believe he could run out the three-year clock on a claimant before the claimant could sue." 488 F.3d at 261. The dissent also stated that, regardless of whether the majority might identify policy

reasons why the default period would be preferable, it is for the plan drafter to determine plan terms, not the courts.

The dissent concluded that it was the majority's refusal to enforce the clear plan language that created uncertainty in the administration of ERISA plans. Under the terms of the plan, from the time the Plaintiff filed her administrative claim, she was on notice that the date by which she was required to file a civil action was August 9, 2003. The dissent concluded that "it is the majority that pulls the rug out from under the parties at this late stage of the litigation by refusing to enforce the plan as written." *Id.* at 262. The dissent also expressed concern that the majority's reliance on federal common law to nullify unambiguous ERISA plan terms "will also leave future claimants and plan administrators under a variety of plans wondering which plan provisions this court will refuse to apply next." *Id.*

REASONS FOR GRANTING THE WRIT

I. THE FOURTH CIRCUIT DECISION WARRANTS REVIEW BECAUSE IT BROADENS A CIRCUIT SPLIT OVER WHETHER OR NOT TO ENFORCE ERISA-GOVERNED INSURANCE POLICY PROVISIONS THAT REQUIRE A LIMITATIONS PERIOD TO BEGIN AT THE TIME PROOF OF CLAIM IS DUE.

Limitations periods are an integral part of any commercial transaction. Likewise with employee benefit plans governed by ERISA. While many limitations periods are statutory, Congress did not include a specific limitations

period applicable to ERISA suits for denied benefits under 29 U.S.C. §1132(a)(1)(B). As a result, lower courts have resorted to the "most analogous" state statutory period except where the ERISA plan itself contains a limitations period, in which case courts have enforced the period where reasonable, in accordance with *Order of United Commercial Travelers v. Wolfe,* 331 U.S. 586, 608 (1947) (holding that it is "well established" that contractual limitations periods are binding between the contracting parties where the period is reasonable). Application of contractual limitations periods is consistent with the principle that where ERISA does not specifically address an issue, "employers have large leeway to design . . . plans as they see fit." *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003).

Where ERISA plans are funded by insurance policies, the policies are required to comply with state insurance laws. *See* 29 U.S.C. §1144(b)(2)(A) (exempting from pre-emption state laws that regulate insurance). For many years, forty-nine states (as well as the District of Columbia and at least two territories) have uniformly required group life, health, and disability insurance policies to include limitations periods that accrue at the time proof of claim is due. App. 98 (chart showing state statutory provisions). In North Carolina, failure to obtain approval of insurance policy forms may constitute an unfair trade practice. *See, e.g., Richardson v. Bank of America,* 643 S.E.2d 410, 425-26 (N.C. App. 2007). Over the past fifteen years, eight circuit courts have weighed in on the question of whether an ERISA-governed insurance policy can require the policy's limitations period to begin at the time the participant's proof of claim is due. The Fifth, Seventh, and Eighth Circuits have held that such a requirement is

enforceable so long as there is reasonable time remaining after the claim process is completed for a participant to file suit. Two unpublished decisions from the Sixth and Tenth Circuits hold likewise. In contrast, the Third, Fourth, and Ninth Circuits prohibit proof of claim accrual provisions in ERISA actions as a matter of law and regardless of whether or not they allow a reasonable time to file suit.

The circuit split is mature: the varied circuit court decisions have been issued over a fifteen-year period. The circuit split is also getting worse, not better. Until 2007, only one circuit – the Ninth – refused to enforce proof of claim accrual provisions, whereas five circuits applied the provisions in ERISA benefit suits. The decision below and a recent Third Circuit decision irrevocably broaden the split. Regardless of how the remaining circuits rule on the issue, the split will continue and is problematic.

A. The Fourth Circuit Decision Conflicts with Published Decisions in the Fifth, Seventh, and Eighth Circuits and with Unpublished Decisions in the Sixth and Tenth Circuits.

Published and unpublished decisions in the Fifth, Sixth, Seventh, Eighth, and Tenth Circuits, have all enforced accrual dates that run from events other than the denial of benefits. *See Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan*, 426 F.3d 330, 337-38 (5th Cir. 2005) (enforcing three-year limitations period that began to run from date proof of loss was due); *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 875 (7th Cir. 1997) (enforcing thirty-nine month limitations period that began to run from the date of the services for which benefits were sought); *Blaske v. Unum*

Life Insurance Company of America, 131 F.3d 763, 764 (8th Cir. 1997), *cert. denied*, 525 U.S. 812 (1998) (enforcing policy limitations provision that began the period at the time that proof of claim was required); *Clark v. NBD Bank, N.A.*, 3 Fed. Appx. 500 (6th Cir. 2001) (enforcing plan limitations period providing that "no action . . . shall be brought after the expiration of three years after the time written proof of loss is required to be furnished"); *Moore v. Berg Enters.*, 1999 U.S. App. LEXIS 30481 (10th Cir. 1999) (enforcing three-year statute of limitations running from the date proof of loss was required).

The Fifth Circuit enforced an ERISA plan's limitations period that required an action to recover benefits to be filed within "three (3) years from the time written proof of loss is required to be given." *Id.* The Fifth Circuit acknowledged that *generally* under ERISA, a cause of action accrues after a claim for benefits has been formally denied. However, in applying a contractual limitations period that began to run from the date proof of loss was due, the Fifth Circuit reasoned: "Because ERISA provides no specific limitations period, we apply state law principles of limitation . . . *Where a plan designates a reasonable shorter time period, however, that lesser limitations schedule governs.*" *Harris*, 426 F.3d at 337 (emphasis added). Although the Fifth Circuit ultimately found the action to be timely, it was only after a lengthy discussion of how the term "loss" should be interpreted so that the court could determine the accrual date as specified by the plan.

Similarly, in the Seventh Circuit decision in *Doe v. Blue Cross & Blue Shield United of Wisconsin, supra*, the plan required that any legal action be commenced within 39 months after the date of the services for which benefits were sought (a health plan was at issue in *Doe*). Unlike

the present case, where the claim review process was uneventful, the plaintiff and the plan in *Doe* were involved in a protracted claim process, which spanned nearly a year and a half of the limitations period. Even so, when the final decision was announced, the plaintiff still had another 17 months to bring suit, but he waited another year and a half. *Doe*, 112 F.3d at 872-73, 875. The Seventh Circuit had no difficulty concluding that the limitations period and accrual date in the employee benefit plan were reasonable "in general and in [that] case." *Id.* at 875. The court noted that, like the present case, the employee had been represented by counsel throughout the administrative appeal process and that the plan provided the plaintiff substantially more than the 30 to 60 days a litigant would ordinarily have to appeal an administrative decision. *Id.* Noting that the plan participant was required to exhaust administrative remedies before filing suit under ERISA, the Seventh Circuit expressed concern that if the internal appeals process took longer than the contractual limitations period, the plaintiff could be barred from suing even though the plan forbade him to sue earlier. *Id.* at 873. However, the court held that the applicable deadline was enforceable in that case because the plaintiff had more than a year after the claim was denied in which to commence suit, a period the court deemed reasonable. *Id.*

In *Blaske v. Unum, supra,* a disability insurance policy provided that any legal action "cannot be maintained after three years from the date that proof of claim is required." 131 F.3d at 763. The plaintiff filed suit after her disability claim was denied. The disability insurer moved for summary judgment on the ground that suit was not filed within the time period specified in the policy.

Finding that the policy period was more liberal than the otherwise applicable state statutory limitations period, the Eighth Circuit applied the policy period and affirmed summary judgment in favor of the insurer.

In *Clark v. NBD Bank, supra*, the Sixth Circuit enforced a plan's limitations provision providing that no action could be brought after the expiration of three years from the time written proof of loss was required. Like *Doe*, the Sixth Circuit relied on *Order of United Commercial Travelers v. Wolfe, supra*, and held that contractual limitations periods are enforceable so long as they are reasonable:

> Courts have adhered to the rule that, 'in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than prescribed in the general statute of limitations, provided that the shorter period itself shall be reasonable.' . . . 'Congress' silence on a limitation period . . . shows its willingness to accept reasonable limitations periods rather than a strong policy in favor of some particular limitations period.' . . . Many courts have specifically applied this general rule of law to claims brought under ERISA.

Clark, 3 Fed. Appx. 500, 503-04 (6th Cir. 2001).

Finally, in *Moore v. Berg Enters., Inc., supra*, the Tenth Circuit enforced an ERISA plan's limitations period that precluded actions to recover benefits filed more than three years after the time proof of claim was required. The Tenth Circuit held that the contractual limitations period and accrual date were reasonable and enforceable:

> ERISA contains no statute of limitations which governs claims under section 1132(a)(1)(B) or section 1132(c). Courts therefore look to the "most analogous" state statute of limitations . . . or if the plan itself contains a limitations period, to the plan if the contractual limitations period is reasonable.

Moore, 1999 U.S. App. LEXIS 30481 at *6-7.

B. The Fourth Circuit Decision is Consistent with Decisions in the Third and Ninth Circuits, Irrevocably Broadening a Long-standing Split in the Circuits.

While the clear weight of authority among the circuits had been to enforce ERISA-governed insurance policy accrual dates that begin to run when proof of claim is due, the Fourth Circuit relied on an older Ninth Circuit case and a recent Third Circuit decision to support its contrary decision. *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986 (9th Cir. 1993); *Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520-21 (3d Cir. 2007).

In *Price v. Provident,* the plaintiff submitted several claims to her medical insurer. The claims were incurred in 1983, but the plaintiff did not file suit until 1991. The health insurance policy required that suits be filed "within three years of the date on which the proof of loss was required to be furnished." The plaintiff argued that, despite the clear language of the policy, the period for filing suit should not begin until he was notified that his claims were denied. Relying on reasoning similar to the Fourth Circuit in this case, the Ninth Circuit held that the policy accrual provision was *per se* unenforceable and that the limitations period would not begin until the plaintiff

had reason to know about the denial. 2 F.3d at 989. The Ninth Circuit remanded the matter to the district court to determine the date on which the plaintiff became aware of his claim.

In *Miller v. Fortis, supra,* the Third Circuit also refused to enforce language in an ERISA-governed policy that stated that an action must be brought no later than "6 years after the time required for submitting the proof has expired." 475 F.3d at 518. The Third Circuit declined to adopt a blanket rule that ERISA limitations periods begin at the time a claim for benefits is denied, as was done by the Fourth Circuit in this case. Instead, the Third Circuit adopted yet another formula, *i.e.*, that a limitations period in an ERISA benefit suit begins to run when there is a "clear repudiation" of a benefit claim, even if that occurs *before* the claim is formally denied. *Id.* at 522-23.

Ironically, the approaches taken by the three circuits that have prohibited proof of claim accrual provisions are not only inconsistent with decisions in five other circuits and with express plan terms, but are also inconsistent with one another. The Third, Fourth, and Ninth Circuits have rejected a uniform insurance policy provision that has existed for years in favor of a supposedly more uniform "default rule" and yet these circuits do not even agree on the default rule. The Fourth Circuit "default" rule is that a limitations period accrues when the claim is denied, which the majority characterized as "the familiar federal accrual standard." *White,* 488 F.3d at 253. The Third Circuit default rule is based on "clear repudiation" of a claim, which it acknowledged may occur before the claim is formally denied. *Miller,* 475 F.3d at 521. The Ninth Circuit applies an accrual rule based on when the claimant has reason to

know about the denial, which may or may not overlap with the "clear repudiation" rule. *Price,* 2 F.3d at 988. Not only do these standards require factual inquiries in each case, something the Fourth Circuit purported to avoid by rejecting proof of claim accrual provisions, but the Third Circuit recognized that the circuits are not in harmony regarding a supposed default accrual rule, stating "we recognize that our application of the clear repudiation rule diverges from that of other courts confronting the same issue." *Id.* at 523. In summary, the three circuits that reject a virtually universal proof of claim accrual provision, in part on the ground that it creates inconsistency, have themselves created even more inconsistency by adopting varying "default" accrual rules.

II. THE FOURTH CIRCUIT DECISION CONFLICTS WITH *ORDER OF UNITED COMMERCIAL TRAVELERS V. WOLFE* WHICH HOLDS THAT CONTRACTUAL LIMITATIONS PERIODS ARE ENFORCEABLE IF THEY ALLOW A REASONABLE TIME TO FILE SUIT.

In establishing default rules for ERISA benefit suits, courts have looked to state law regarding the length of limitations periods, *see Wilson v. Garcia,* 471 U.S. 261, 266-67 (1985), while holding that federal law governs the date when the limitations period commences, *see Rawlings v. Ray,* 312 U.S. 96, 98 (1941). Notwithstanding the existence of these default rules,

> it is well established that, in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general

> statute of limitations, provided that the shorter period shall be a reasonable period.

Wolfe, 331 U.S. at 608. As the Fourth Circuit dissent concluded, the *Wolfe* rule clearly applies to an ERISA plan which "is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire." 488 F.3d at 258; *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998). Under *Wolfe*, the limitations period in the plan must be enforced unless controlling law prohibits its modification of the default rule or the period provided in the plan is unreasonable. Neither of these circumstances exists in this case:

- No controlling law prohibits adoption of the limitations period specified in the Policy. As the dissent noted, "a federal rule concerning when a limitations period begins *in the absence of an agreement to adopt a shorter period* certainly is not a rule prohibiting adoption of a shorter period." 488 F.3d at 258 (emphasis added).

- The Policy's three-year contractual limitations period, which begins to run on the date proof of claim is required under the Policy, is not only reasonable but, as the dissent concluded, is "eminently reasonable – generous even" and "well constructed to prevent a suit too temporally removed from the events underlying it." 488 F.3d at 263. The Respondent never claimed that the limitations period was unreasonable or unclear, nor could she.

The Policy expressly stated that "[n]o legal action may start . . . more than 3 years after the time Proof of Claim is

required," which equated to August 9, 2003. Petitioner denied Respondent's claim on August 15, 2000 and then denied her appeal on March 28, 2001. Respondent, who was represented by counsel, had no further administrative remedies to exhaust and had *more than 28 months* to file suit. Yet, for some as yet unexplained reason, Respondent waited until March 26, 2004 to file suit – more than seven months too late. The sole criterion for evaluating the Policy limitations period under *Wolfe* was whether the period was reasonable. Under the circumstances, there is no dispute that the period was reasonable.

III. THE FOURTH CIRCUIT DECISION IS INCORRECT AND CREATES AN INTOLERABLE BURDEN FOR ERISA PLANS AND THEIR FIDUCIARIES.

The Fourth Circuit decision is incorrect because it is contrary to *Wolfe*. There is no question that the Policy limitations period allowed Respondent reasonable time to file suit after the final denial of her claim. That should have been the sole consideration under *Wolfe*. The Fourth Circuit majority refused to follow *Wolfe* on the ground that the plan's limitations period would require case-by-case review to decide whether the period of time left after a claim was denied was "reasonable." However, this logic ignores the fact that, under *Wolfe,* federal courts are already required to determine if a period is reasonable whenever a contract alters the otherwise applicable statutory limitations period. The question of reasonableness which the Fourth Circuit sought to avoid is no different than myriad other questions such as tolling and estoppel that require analysis of underlying facts and that routinely arise whenever a limitations period is in question. The fact

that the same questions might arise in the context of the plan's limitations period is certainly no reason to ignore it. The fact that the Fourth Circuit decision is contrary to *Wolfe* demonstrates that the decision has an impact well beyond ERISA, affecting the very basics of parties' freedom to determine the terms of their contract.

The Fourth Circuit decision is incorrect and creates an intolerable burden for ERISA plans and their administrators and fiduciaries because it relies on vague policy principles to vitiate the unambiguous terms of an ERISA plan. ERISA plan terms are paramount. The statute requires ERISA plans to be "established and maintained pursuant to a written instrument." 29 U.S.C. §1102(a)(1). Informal amendment of ERISA plans is prohibited and ERISA plan terms can only be amended where the plan "provide[s] a procedure for amending such plan, and for identifying the persons who have authority to amend the plan." 29 U.S.C. §1102(b)(3). ERISA plan fiduciaries are required to discharge their duties "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104(a). ERISA even provides specific causes of action for participants, beneficiaries, and fiduciaries to enforce written plan terms. 29 U.S.C. §1132(a)(1)(B) (permitting participants and beneficiaries to recover benefits due "under the terms of [the] plan" and to enforce their rights "under the terms of the plan"); §1132(a)(3) (permitting participants, beneficiaries, and fiduciaries to obtain injunctive and other appropriate equitable relief "to enforce . . . the terms of the plan" or to redress violations of "the terms of the plan"). ERISA's requirement that benefit plans be in writing is a "core functional requirement" of the statutory scheme and "'[a] written plan is to be required in order that every employee may, *on examining*

the plan documents, determine exactly what his rights and obligations are under the plan.'" *Curtiss-Wright Corporation v. Schoonejongen*, 514 U.S. 73, 83 (1995) (emphasis by Supreme Court) (quoting H.R. Rep. No. 93-1280, p. 297 (1974)). Here, *on examining the plan documents,* Respondent knew the deadline for filing suit from the moment she became disabled. The Fourth Circuit majority's application of a federal common law default accrual rule that is nowhere in ERISA and that directly contradicts the Policy, can only create confusion, the very thing that Congress intended to avoid when it mandated that benefit plans be in writing. This confusion is further exacerbated by the fact that the other circuit court decisions on which the majority relied adopt different default accrual rules than the rule ultimately adopted by the majority.

The Fourth Circuit decision is incorrect and creates an intolerable burden for ERISA plans and their administrators and fiduciaries because it opens up all plan terms to possible prohibition on the ground that they are in "tension" with general policies of ERISA. ERISA contains very little regulation of the substantive terms of ERISA welfare plans. This absence of specific regulation is generally viewed as leaving plan administrators broad discretion to tailor plans to their needs. *Black & Decker v. Nord, supra.* Indeed, creation of and changes to plan language are not even considered fiduciary functions under ERISA and remain virtually unregulated. *See, e.g., Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432, 443 (1999) (the creation and amendment of plan terms is not a fiduciary function under ERISA and is not regulated by ERISA); *Lockheed Corp. v. Spink,* 517 U.S. 882, 890 (1996) (employers who alter terms of ERISA plans do not act as fiduciaries); *Curtiss-Wright v. Schoonejongen,* 514 U.S. at 100 ("Employers and

other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."). Plan sponsor discretion may be somewhat limited when a plan is funded by insurance because insurance policies are subject to state insurance laws. But the decision below demonstrates that even state insurance laws are susceptible to prohibition at the hands of general default rules that are solely the creatures of federal common law.

The Fourth Circuit decision is incorrect and creates an intolerable burden for ERISA plans and their administrators and fiduciaries because it evidences a patent inconsistency in the enforcement of ERISA plan limitations periods. It is likely that the Fourth Circuit would have upheld a limitations period of 28 months (and probably a much shorter period) if the period began when the claim was denied. One can say this because the Fourth Circuit majority did not dispute that the 28-month period was reasonable and because federal courts have routinely found contractual limitations periods in ERISA-governed employee benefit plans as short as 45 days, 90 days, and one year to be reasonable. *Davidson v. Wal-Mart Assoc. Health and Welfare Plan*, 305 F. Supp.2d 1059 (S.D. Iowa 2004) (45-day limitations period enforced as bar to plaintiff's claim); *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998) (enforcing 90-day limitations period); *Koonan v. Blue Cross & Blue Shield of Virginia*, 802 F. Supp. 1424 (E.D. Va. 1992) (enforcing a plan's one-year limitations period). These short limitations periods are almost presumed reasonable due to the nature of an ERISA claim for benefits:

> A suit under ERISA, following as it does upon the completion of an ERISA-required internal appeals process, is the equivalent of a suit to set aside an administrative decision, and ordinarily no more than 30 or 60 days is allowed within which to file such a suit . . . Like a suit to challenge an administrative decision, a suit under ERISA is a review proceeding, not an evidentiary proceeding. It is like an appeal, which in the federal courts must be filed within 10, 30, or 60 days of the judgment appealed from . . . depending on the nature of the litigation, rather than like an original lawsuit.

Doe v. Blue Cross & Blue Shield United of Wisconsin, 112 F.3d 869, 875 (7th Cir. 1997). Yet here, where the Respondent was left with a much longer amount of time to file suit after her claim was denied (over 28 months), the limitations period was deemed unenforceable, solely because it began when her proof of claim was due and because the accrual clause created the *hypothetical possibility* that a shorter time period might result from facts not present in this case. Certainly, unambiguous plan terms should not be deemed inapplicable based solely on hypothetical facts that have nothing to do with the case at hand.

The upshot of the Fourth Circuit decision is that 28 months was not deemed reasonable merely because the limitations period accrued when Respondent's proof of claim was due, whereas much shorter periods of 45 days, 90 days, and one year have routinely been held reasonable under ERISA and likely would have been upheld in this case. The root of this inconsistency appears to be the majority's assumption that Respondent had a limitations

period of three years under the Policy. She did not; Respondent had three years "*after the time Proof of Claim is required.*" As the dissent noted in discussing *Doe, supra,*

> In applying the *Wolfe* reasonableness rule, *Doe* considered the appropriateness of the 'limitations *period*' . . . which it correctly understood to include the event that commences the period as well as the length of the period.

488 F.3d at 262 (emphasis in original). The majority failed to understand that the Policy limitations clause is a unit consisting of both a commencement date *and* a length of time. This failure led the majority to rob the Policy limitations provision of its operative language.

IV. THIS CASE PROVIDES THE IDEAL VEHICLE FOR RESOLVING THE CIRCUIT SPLIT.

There are several reasons why this case provides the ideal vehicle for resolving the circuit split and the conflict with *Wolfe.* The Policy language at issue is unambiguous, so there are no debates about proper interpretation. The Policy language is also virtually universal, being mandated for inclusion in disability and similar insurance policies by forty-nine states, so the impact of the Fourth Circuit decision goes well beyond this case. In fact, literally hundreds of insured ERISA welfare plans have been told, in essence, that although plan terms may be clear and unambiguous and may even be mandated by state insurance laws, they are still subject to challenge based on vague notions of public policy. The claim review process in this case was uneventful, in full compliance with applicable procedural regulations, and free of any undue delays. Indeed, the hypothetical drawbacks that might conceivably result

from an accrual at the time proof of claim is due, as identified by the district court and the Fourth Circuit majority, were not even present in this case. From a procedural standpoint, this case presents the ideal scenario for resolution of the issue presented. Finally, this case also has the ideal factual background for review because the claim process was completed in time to leave Respondent with over 28 months to file suit, a time period that everyone conceded was reasonable. The legal issue of whether a proof of claim accrual clause can be applied in an ERISA benefits dispute is squarely before the Court and is ripe for review.

CONCLUSION

For the reasons stated herein, Petitioner respectfully requests that this Court grant review and reverse the ruling below.

Respectfully Submitted,

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September 7, 2007

PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

MARGARET T. WHITE,

Plaintiff-Appellee,

v.

SUN LIFE ASSURANCE COMPANY OF CANADA,

Defendant-Appellant,

and

GREER LABORATORIES, INCORPORATED; GREER LABORATORIES, INCORPORATED EMPLOYEE LONG TERM DISABILITY PLAN; PLAN ADMINISTRATOR OF THE GREER LABORATORIES, INCORPORATED LONG TERM DISABILITY PLAN,

Defendants.

No. 06-1285

MARGARET T. WHITE,

Plaintiff-Appellee,

v.

SUN LIFE ASSURANCE COMPANY OF CANADA,

Defendant-Appellant,

and

No. 06-1491

GREER LABORATORIES, INCORPORATED; GREER LABORATORIES, INCORPORATED EMPLOYEE LONG TERM DISABILITY PLAN; PLAN ADMINISTRATOR OF THE GREER LABORATORIES, INCORPORATED LONG TERM DISABILITY PLAN,

Defendants.

Appeals from the United States District Court for the Western District of North Carolina, at Asheville. Lacy H. Thornburg, District Judge. (1:04-cv-00080)

Argued: December 1, 2006

Decided: April 26, 2007

Before WILKINS, Chief Judge, WILKINSON, Circuit Judge, and Henry F. FLOYD, United States District Judge for the District of South Carolina, sitting by designation.

Affirmed by published opinion. Judge Wilkinson wrote the majority opinion, in which Judge Floyd joined. Chief Judge Wilkins wrote a dissenting opinion.

COUNSEL

ARGUED: Mark Eugene Schmidtke, SCHMIDTKE HOEPPNER CONSULTANTS, L.L.P., Valparaiso, Indiana, for Appellant. Charles McBrayer Sasser, Charlotte, North Carolina, for Appellee. **ON BRIEF:** Anuja G. Purohit, POYNER & SPRUILL, Raleigh, North Carolina, for

Appellant. Thomas L. Hudson, OSBORN MALEDON, P.A., Phoenix, Arizona, for Appellee.

OPINION

WILKINSON, Circuit Judge:

This case requires us to determine whether a benefit plan can start the statute of limitations running on a plan participant's cause of action for benefits under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.* (2000), before the plan participant can even file suit. Plaintiff-appellee Margaret T. White brought suit against defendant-appellant Sun Life Assurance Company of Canada "to recover benefits due to [her] under the terms of [her] plan" for disability insurance. 29 U.S.C. § 1132(a)(1)(B). Sun Life seeks to bar this federal claim based upon a provision in the plan's governing document stating, "No legal action may start . . . more than 3 years after the time Proof of Claim is required." A plan participant applies for benefits by filing a proof of claim, but she may not bring a legal action until her plan has reached a final decision denying benefits.

We agree with the district court that ERISA's remedies framework does not permit a plan to start the clock on a claimant's cause of action before the claimant may file suit. We also agree that Sun Life erred in denying White disability benefits, and therefore affirm the decision below.

I.

A.

Plaintiff Margaret White received long-term disability insurance from Sun Life under a plan provided through

her family's business, Greer Laboratories, Inc., where she worked from 1984 until 2000. White resigned on February 11, 2000 from the position of vice president of administration, in which her duties had included coordinating the work of staff, reviewing subordinates' work, and attending management meetings.

After leaving Greer Laboratories, White filed an application for disability benefits with Sun Life, claiming total disability. Sun Life's provision for total disability provides monthly payments to a covered employee who "because of Injury or Sickness, is unable to perform all of the material and substantial duties of his own occupation." The policy defines "Injury" as "bodily impairment resulting directly from an accident and independently of all other causes" and "Sickness" as "illness, disease or pregnancy."

White based her claim upon chronic pain from piriformis syndrome, a neuromuscular disorder that occurs when the piriformis muscle compresses or irritates the sciatic nerve. White reported that she experienced lower back pain radiating down her right leg after performing household labor in August of 1997, and that this evolved into a chronic pain and, over time, moved to her left leg.

In 1997, White sought help from Dr. David Jones, a board-certified neurosurgeon. She began to see a pain management specialist, Dr. Felicia Cain, the following year. The doctors were unable to pinpoint the source of White's pain, despite diagnostic steps such as an MRI scan, CT scan, and myelogram. White was prescribed pain medication and muscle relaxants, but she reported that her pain worsened despite these treatments.

Dr. Jones referred White for a surgical consultation with David Kline, chairman of the neurosurgery

department at Louisiana State University, whom Dr. Jones described as "a nationally recognized expert in the surgical treatment of peripheral nerve disorders." Dr. Kline warned White that surgery would not necessarily be a cure, describing "the possibility of not helping, and the possibility of deficits." White chose to undergo surgery nonetheless on April 21, 1999. Dr. Kline wrote that the surgery revealed a serious physical abnormality. The piriformis muscle "was quite deformed and tethering the peroneal nerve division, which it had split, and was running in between." Dr. Kline resectioned the piriformis muscle and removed tissue from around the sciatic nerve.

After surgery, White reported initial improvement in June and early July of 1999. By July 23, however, she was again reporting significant pain as well as depression. Dr. Cain wrote that day that "[p]iriformis syndrome [was] still causing the patient a great deal of pain," and that White had "an extreme amount of depression secondary to her inability to do anything and pain and inability to sleep." She increased White's dosages of a painkiller and an antidepressant, and had White sign a narcotics contract regarding her use of the medications.

White's July appointment with Dr. Cain was not the only occasion on which a doctor observed that the claimant suffered from depression. Dr. Cain diagnosed depression again on September 22, 1999, for instance, and wrote that White suffered from "problems at work as well as at home secondary to pain and its limitations on her life." Dr. David Abernathy, a longtime physician of White's, wrote during the summer after White's surgery that he did not "see a way around" White's medications. "Maggie complains of a lot of pain that is seemingly not understood according to her by her family," he noted. "She is in an

executive position in a company here that is family owned and has been given almost some ultimatums about leaving the company."

Both Dr. Jones and Dr. Cain wrote that the patient was still struggling with pain in the summer and fall. While White had gradually returned to work and was working five days a week in October of 1999, Dr. Jones wrote in October that the patient was "going to cut back to 3 days a week beginning soon" and added, "I think this would help her." He wrote that the patient "continues to take fairly hefty doses" of pain medicines under the supervision of Dr. Cain but that White "has managed very well with this" and was adhering to her narcotic contract with Dr. Cain. Nevertheless, White told Dr. Cain on February 3, 2000 that she was unable to sit for any length of time, and that the only way she could relieve pain was to lie on her right side. Dr. Cain added, "[A]lthough she continues to try to function in a full-time capacity, she feels this is becoming intolerable secondary to pain."

White left work that month, on February 11. She continued to see her doctors after leaving Greer Laboratories, and Sun Life relies heavily on a letter generated during one such visit as supporting its denial of benefits. Dr. Kline wrote to Dr. Jones on March 20, 2000, after seeing White for a follow-up appointment:

> She has had inexplicable buttock level pain and sciatica for a number of years . . . [A]fter some relief of her pain in the buttock, it has come back. She also has some low back pain and some pain occasionally on the anterior side of the thigh. It occasionally goes all the way to the calf. She has stopped her work, but that is more because of familial problems and work problems than her

> disability and difficulty with her back and leg. She is tender in the low back, particularly to the left . . . She has decreased range of motion to the back, particularly full flexion. Straight leg raising gives mainly low back rather than buttock or leg pain. This is so also with reverse straight leg raising.

Dr. Kline described White's "sciatic function" on the right and left sides as "excellent . . . grading 5/5." He wrote, "I think pain management we will leave in your hands," but recommended swimming and physical therapy exercises. "We will see her again in six months and only wish there was more we could do for her," Dr. Kline wrote.

Dr. Jones spoke with White via phone on March 28, leading him to write that White "continues to be miserable. She is considering applying for long term disability, and at this point I think that is probably the only option left to her." Dr. Jones also noted that White had undergone another MRI scan, which showed "no change" from the scan before surgery in 1998.

Dr. Cain wrote that month that White's pain had worsened since surgery and that the patient still required large doses of pain medications and was experiencing "a great deal of distress secondary to this illness." She suggested White seek treatment for depression, which White declined because she did not believe it would help. Dr. Cain increased White's dosage of pain medication on that visit, and White reported an improvement in her condition in April, when Dr. Cain wrote that the patient "appears to have seen an increase in her affect as well as decrease in depression" since leaving her job. White described similar levels of pain during the summer of 2000, but Dr. Cain wrote that White was still only "able to

be active 2-3 hours per day and then must rest in order to decrease pain."

B.

White applied for long-term disability benefits in an application dated May 5, 2000. Dr. Jones stated in support of White's application that since February 18, 2000, she had been completely unable to work given her physical limitations, would never be able to work, and was not capable of performing another occupation on a full or part-time basis.

Sun Life's claims consultant recommended that a physician-consultant, Dr. Sarni, review White's file. She stated that "[a] doctor to doctor call may be helpful" in the review. Dr. Sarni did not consult any of White's treating physicians, however, nor did he or any other physician examine White on behalf of the insurer, as Sun Life was entitled to do under its plan. Instead, Dr. Sarni drafted a brief memorandum containing broad assertions about the appropriateness of the plaintiff's treatment given her condition – assertions that had not been made by either of the neurosurgeons or the pain specialist who treated White over an extended period.

Dr. Sarni described White's regimen of painkillers and her prescription for the muscle relaxant Valium, in addition to quoting Dr. Kline's March 20, 2000 report stating that White stopped work "more because of familial problems and work problems than her disability." Dr. Sarni then wrote: "These are extremely high doses of very addictive medication. All of this medication also goes to reset the pain threshold. Such pain complaints are far out of proportion to the pathology described. There is no

objective data at this point to support such significant impairments."

Sun Life denied White's claim. White appealed in October of 2000 and submitted additional medical records, as well as a new letter from the neurosurgeon Dr. Jones explaining his conclusion that White was "disabled from performing any work on a continued and sustained basis due to her ongoing symptoms of chronic pain that have arisen from her peripheral nerve disorder," and had been disabled "since at least February, 2000."

Sun Life again referred White's file to Dr. Sarni, who dismissed Dr. Jones' conclusions in another one-page letter. Dr. Sarni asserted that Dr. Jones' conclusions were in "direct contradiction" to the March 20, 2000 follow-up letter from Dr. Kline, although Dr. Kline had not questioned Dr. Jones' conclusions in his letter and Dr. Sarni had communicated with neither Dr. Kline nor Dr. Jones nor any other treating physician. Sun Life also submitted White's file to a vocational consultant. The consultant echoed Dr. Sarni's interpretation of Dr. Kline's report as indicating that family problems were the source of White's inability to perform her work responsibilities and concluded, "It is not clear to me what specifically precludes her from doing her sedentary job." Sun Life informed White that her appeal had been denied in a letter dated March 28, 2001.

White filed suit under ERISA on March 26, 2004, seeking benefits under the terms of Sun Life's disability plan.[1] Sun Life sought to dismiss White's ERISA claim on

[1] White also raised state law claims that the district court held were pre-empted by ERISA, a decision that White does not appeal.

the grounds that it was time-barred as a result of the provision in Sun Life's plan stating that the statute of limitations began to run at an earlier date than federal law would ordinarily provide. The district court found this plan provision was contrary to ERISA's statutory scheme, and later determined that Sun Life's denial of disability benefits had been an abuse of discretion. Sun Life now appeals.

II.

A.

Sun Life first contends that White's complaint should be deemed untimely. This is not a result dictated by the language of ERISA itself: Like many federal laws, the cause of action for benefits due under an ERISA plan does not contain a statute of limitations, nor does it specify when the statute begins to run. *See* 29 U.S.C. § 1132(a)(1)(B) (2000). As a default, courts faced with such omissions borrow the state law limitations period applicable to claims most closely corresponding to the federal cause of action, *see Wilson v. Garcia,* 471 U.S. 261, 266-67 (1985), but treat the time at which the statute begins to run as governed by a uniform federal rule rather than the laws of the states, *see Rawlings v. Ray,* 312 U.S. 96, 97-98 (1941); *Blanck v. McKeen,* 707 F.2d 817, 819 (4th Cir. 1983). The clock generally begins to run at the time a plaintiff can first file suit. "While it is theoretically possible for a statute to create a cause of action that accrues at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit," the Supreme Court has written, "we will not infer such an odd result in the absence of any such indication in the statute." *Reiter v. Cooper,* 507 U.S.

258, 267 (1993). Thus, *Reiter* held that payment of a tariff was not a prerequisite to litigating the tariff's reasonableness under the Interstate Commerce Act, notwithstanding a prior Supreme Court decision suggesting otherwise, on the grounds that Congress' subsequent change to the accrual date should be understood to control both for statute of limitations purposes and for the purpose of determining when a claim could be brought. *Id.*

The ERISA accrual rule we have set forth based upon these principles is plain and unconditional, and Sun Life does not dispute that its application would make the plaintiff's complaint timely. We have held: "An ERISA cause of action does not accrue until a claim of benefits has been made and formally denied." *Rodriguez v. MEBA Pension Trust,* 872 F.2d 69, 72 (4th Cir. 1989). Other circuits have adopted this same accrual rule for ERISA actions. *See Hall v. Nat'l Gypsum Co.,* 105 F.3d 225, 230 (5th Cir. 1997); *Daill v. Sheet Metal Workers' Local 73 Pension Fund,* 100 F.3d 62, 66-67 (7th Cir. 1996); *Stevens v. Employer-Teamsters Joint Council No. 84 Pension Fund,* 979 F.2d 444, 451 (6th Cir. 1992); *Martin v. Construction Laborers Pension Trust for S. Cal.,* 947 F.2d 1381, 1386 (9th Cir. 1991); *Mason v. Aetna Life Ins. Co.,* 901 F.2d 662, 664 (8th Cir. 1990). This means that the statute of limitations begins to run at the moment when the plaintiff may seek judicial review, because ERISA plaintiffs must generally exhaust administrative remedies before seeking judicial relief. *See Makar v. Health Care Corp. of the Mid-Atlantic (Carefirst),* 872 F.2d 80, 81 (4th Cir. 1989).

Sun Life asks us, however, to disregard all the usual rules of accrual and to hold that ERISA plans may specify different accrual dates in their governing documents. It relies in large part upon a contracting case preceding the

enactment of ERISA, which stated that "in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period." *Order of United Commercial Travelers of America v. Wolfe,* 331 U.S. 586, 608 (1947). The Supreme Court did not discuss or have before it in *Wolfe* a provision such as Sun Life's that set potential plaintiffs' limitations periods running before they could even file suit. And as the dissent acknowledges, *see post* at 27-28, ERISA plans are not classical commercial contracts of the sort at issue in *Wolfe.* To be sure, ERISA does confer upon plans substantial power to set their terms: We have held that "[p]lan sponsors, not federal courts, are empowered by ERISA 'to adopt, modify, or terminate welfare plans,'" and we reaffirm "the well-established principle that plans can craft their governing principles as they think best." *Gayle v. United Parcel Service, Inc.,* 401 F.3d 222, 228 (4th Cir. 2005) (quoting *Curtiss-Wright Corp. v. Schoonejongen,* 514 U.S. 73, 78 (1995)).

This principle is not boundless, however. Even setting aside the differences between the contract in *Wolfe* and an ERISA plan containing an accrual provision such as Sun Life's, we cannot enforce the provision. Parties may establish such accrual provisions only "in the absence of a controlling statute to the contrary," *Wolfe,* 331 U.S. at 608, and the accrual provision in the plan flies in the face of the ERISA statutory framework. Moreover, the endless judicial "reasonableness" oversight that the dissent would enlist to save the accrual provision immerses courts in an

extra-contractual and extra-statutory endeavor that is incompatible with ERISA's written-plan requirement.

B.

The first barrier to Sun Life's accrual provision is the remedies framework established by the ERISA statute. ERISA imposes limits on plan autonomy through substantive and procedural requirements intended to protect "the interests of participants in employee benefit plans and their beneficiaries" and provide "for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b) (2000). Plan drafters enjoy broad latitude, but they cannot write over the constraints established by federal law.

Sun Life would do just that by starting the clock on its participants' claims before the participants can even file suit. The company's accrual provision runs afoul of the statute's scheme of mutually reinforcing remedies by using the internal review mechanisms mandated by ERISA in a manner that undermines and potentially eliminates the ERISA civil right of action. Internal appeals are one cornerstone of ERISA: The statute requires that "every employee benefit plan shall – afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). But judicial review is another: When internal review mechanisms do not resolve a dispute over benefits, a plan participant may challenge the plan's decision in court. *See* 29 U.S.C. § 1132(a); *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996) (holding that ERISA's stated objective of providing "ready access to the Federal courts" disfavors

interpretation of statute that would strip beneficiaries of ability to file suit).

These remedies must be interpreted in light of each other. Thus, although ERISA does not explicitly state that claimants must exhaust internal appeals before filing suit, courts have universally found an exhaustion requirement in part because statutory text and structure establish these twin remedies of administrative and judicial review as parts of a single scheme. *See Makar,* 872 F.2d at 82-83; *see also Whitehead v. Okla. Gas & Elec. Co.,* 187 F.3d 1184, 1190 (10th Cir. 1999) (holding that ERISA requires exhaustion for benefits claims); *Springer v. Wal-Mart Assocs.' Group Health Plan,* 908 F.2d 897, 899 (11th Cir. 1990) (same); *Miller v. Metro. Life Ins. Co.,* 925 F.2d 979, 986 (6th Cir. 1991) (same); *Weldon v. Kraft, Inc.,* 896 F.2d 793, 800 (3d Cir. 1990); *Leonelli v. Pennwalt Corp.,* 887 F.2d 1195, 1199 (2d Cir. 1989) (same); *Drinkwater v. Metro. Life Ins. Co.,* 846 F.2d 821, 825-26 (1st Cir. 1988) (same); *Denton v. First Nat'l Bank of Waco, Tex.,* 765 F.2d 1295, 1297 (5th Cir. 1985) (same), *reh'g denied,* 772 F.2d 904 (5th Cir. 1985); *Kross v. W. Elec. Co.,* 701 F.2d 1238, 1244-45 (7th Cir. 1983) (holding district court has discretion to require exhaustion and ERISA statute favors doing so); *Amato v. Bernard,* 618 F.2d 559, 566-68 (9th Cir. 1980) (same).[2]

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[2] The symbiotic nature of ERISA remedies is also evident in regulations concerning the notice that ERISA plans must provide to claimants upon denial of benefit claims as part of the plan's obligations with respect to "full and fair review." The civil action is treated as an integral part of this review: plans are directed to include a "description of the plan's review procedures and the time limits applicable to such procedures, *including a statement of the claimant's right to bring a civil*

(Continued on following page)

This interlocking remedial structure does not permit an ERISA plan to start the clock ticking on civil claims while the plan is still considering internal appeals. Courts have required exhaustion in light of the symbiotic relationship between ERISA civil suits and internal review, but Sun Life would allow one remedy to undercut the other. Benefit plans would have the incentive to delay the resolution of their participants' claims, because every day the plan took for its decision-making would be one day less that a claimant would have to review the plan's final decision, decide whether to challenge it in court, and prepare a civil action if need be. Indeed, a plan that did not reach a final decision until after the statute of limitations had run would deprive a participant of the right to file a civil claim at all. These incentives to delay would undermine internal appeals processes as mechanisms for "full and fair review," *see* 29 U.S.C. § 1133(2), and undermine the civil right of action as a complement to internal review, *see Varity,* 516 U.S. at 513 (noting ERISA is designed to develop "a sensible administrative system").

C.

Sun Life acknowledges that its rule creates tension between internal and judicial review requirements, but it proposes to resolve these tensions through case-by-case review of the "reasonableness" of the time allotted a claimant to file suit. But this approach is also sharply at odds with ERISA.

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action" following an adverse benefits determination. 29 C.F.R. § 2560.503-1(g)(iv) (emphasis added).

Sun Life does not dispute that across-the-board enforcement of its own accrual provision would be inconsistent with ERISA's scheme of remedies, given the difficulty of allowing plans to deprive their participants of any or virtually any time in which to file civil suit. Every claimant covered by an accrual provision such as Sun Life's would have less than the full limitations period available to file suit, and Sun Life acknowledges that a plan's prolonged deliberations could in some cases deprive claimants of a reasonable opportunity to file their civil actions. Sun Life urges us, however, to assess the reasonableness of this compression on a case-by-case basis: "If the limitations period, including the accrual date, is unreasonable, then a different limitations period should apply." Reply Brief of Appellant at 7-8. The insurer argues that its accrual provision should be enforced on the grounds that undue delay or abuse of internal appeals were "not the circumstances in the present case," because Sun Life decided White's benefits claim with more than two years remaining on the statute of limitations that the plan sets forth. Brief of Appellant at 40.

Whatever the "reasonableness" of the time available to this particular claimant, Sun Life's approach provides no basis for a workable rule. Indeed, a case-by-case approach to contractual accrual provisions creates as many problems as it would solve. It would be simple to disregard plan-specified accrual dates when a plan took so long to make a final benefits determination that a claimant was left with no time at all in which to file suit. But courts would have no ready means of determining, as Sun Life proposes, how much "compressing" of the plaintiff's limitations period was too "severe [] ." Brief of Appellant at 40 (quoting district court opinion). These questions

could not be answered by an analysis of the plan document alone, because whether an accrual provision was "reasonable" with respect to a particular claimant would change each day that the plan did not issue a final decision. Moreover, while a case-by-case approach might give courts a means to intervene in egregious cases, it would not eliminate the perverse incentives to delay the resolution of claims. Courts would be hard pressed to ascertain whether these incentives caused a plan to delay a decision, despite the way in which such manipulation of the internal review process undermines both ERISA's civil remedy and internal appeals as mechanisms of "full and fair review."

Perhaps most importantly, the manner in which Sun Life proposes to reconcile internal and judicial review would come at the expense of ERISA's "written plan" and participant-notification requirements, as well as the values of notice and certainty that these requirements serve. ERISA affords plans broad powers over substance and procedure, but it requires that plans act through written documents, stating, "Every employee benefit plan shall be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). The Supreme Court has described this as a "core functional requirement[]" that aims to ensure that "every employee may, *on examining the plan documents,* determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp.*, 514 U.S. at 83. Plans must also provide participants with written notification if they deny benefits, describing "the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action," 29 C.F.R. § 2560.503-1(g)(iv), written "in a manner calculated to be understood by the

claimant," *id.* § 2560.503-1(g); *see also* 29 U.S.C. § 1133(1) (setting forth statutory notice requirement).

A sometimes-enforcing approach to accrual provisions would disregard the written plan requirement and make it impossible for plans to give their participants the notice of subsequent remedies required by law. The "reasonable[ness]," "severe[] compress[ion]" or "ample time," rule that Sun Life seeks to have enforced is nowhere contained in its written plan. Brief of Appellant at 40; Reply Brief of Appellant at 6. Contractual accrual periods like Sun Life's would be enforced sometimes, but not at other times, according to a standard neither contained in the plan document nor evident from its terms. *Cf. United McGill Corp. v. Stinnett,* 154 F.3d 168, 172 (4th Cir. 1998) ("ensur[ing] the integrity of written, bargained-for benefit plans" requires that "the plain language of an ERISA plan must be enforced in accordance with 'its literal and natural meaning' ") (internal citation omitted).

Rather than apprising plan participants of their rights, the written plan would often mislead claimants by setting forth a purported time limitation that would, in reality, apply only if it satisfied a reasonableness analysis described nowhere in the plan. Some claimants might conclude the permissible time had passed and not pursue their claim; others might conclude that it was not worth the effort to litigate a threshold inquiry into reasonableness. Whatever the effects, reasonableness is a subjective standard whose application to a particular claimant would shift over time. As a result, neither a plan participant nor even a court could determine at the moment that a participant filed proof of claim whether his legal cause of action would accrue as provided under the plan's terms.

Sun Life insists that declining to enforce this accrual and limitations provision would amount to holding that "the express federal statutory mandate that ERISA plans should be enforced according to their terms is somehow trumped by a federal common law principle." Reply Brief of Appellant at 1. But it is Sun Life's position that relies on standards nowhere mentioned in the plan and it is Sun Life's position that immerses federal courts in a federal common law enterprise that would undermine the ERISA framework. Nowhere does Sun Life explain the origins in law of its chosen terminology. Nowhere in Sun Life's plan are the standards for when enforcement of an accrual period would be "unreasonable," Brief of Appellant at 8, would not provide a claimant "ample time," Reply Brief of Appellant at 6, or would have the effect of "severely compressing" a claimant's window for filing, Brief of Appellant at 40 (quoting district court opinion). And Sun Life provides no guidance as to how courts should undertake the extra-statutory and extra-contractual inquiry it proposes, except to say that its own accrual provision was "eminently reasonable as applied to the facts in this case." Brief of Appellant at 39.

The fact-dependent scenarios that Sun Life advocates would run counter to the values of certainty and predictability at the heart of most accrual and limitations rules. Such a rule of federal common law would be particularly incompatible with ERISA, given its written plan requirement and its statutory directive that plans make the rights of their participants clear to non-legal readers. *See, e.g.*, 29 U.S.C. § 1133(1). In short, the insurer's approach would impose upon courts a federal common law methodology less compatible with the ERISA framework than the

familiar accrual rule that federal courts have presumptively applied.

The decisions of other courts do not persuade us otherwise. The Ninth Circuit has deemed accrual provisions such as Sun Life's unenforceable, concluding that such provisions create incentives for plans to use their governing documents to undermine their participants' civil claims -- in the case before it, for instance, by making claims accrue when proof of loss was due and allowing the statute to expire before a plan participant knew that his claim had been denied. *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993). "ERISA," the Ninth Circuit wrote, "does not permit such a result." *Id.; see also Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520 (3d Cir. 2007) (rejecting district court's holding that accrual date should be taken from plan document because "the accrual date for federal claims is governed by federal law, irrespective of the source of the limitations period").

While the Seventh Circuit enforced a contractual accrual date, the focus of its opinion was on plans' freedom to set limitations periods, not accrual dates. *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 873-75 (7th Cir. 1997).[3] We could not agree more that ERISA generally affords plans the flexibility to set limitations periods, nor do we take issue with those decisions enforcing contractual limitations periods of varying lengths. *See,*

[3] A Fifth Circuit decision that Sun Life also cites does not bear directly upon this case, because while the Fifth Circuit applied a plan's accrual and limitations provision, neither party in the case had challenged the provision and the plaintiff prevailed. *Harris Methodist Fort Worth v. Sales Support Servs. Inc. Employee Health Care Plan*, 426 F.3d 330 (5th Cir. 2005).

e.g., Wilkins v. Hartford Life & Accident Ins. Co., 299 F.3d 945, 948-49 (8th Cir. 2002) (barring suit based upon three-year contractual limitations period that would have expired even if statute were tolled during plan's consideration of claim); *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301, 1302-04 (11th Cir. 1998) (enforcing ninety-day limitations period that did not begin to run until denial of claim). Plans may legitimately wish to avoid extended limitations periods, because the disability status of a particular plaintiff may shift significantly over time, and because both the interests of claimants and a plan's own accounting mechanisms may be served by prompt resolution of claims. Our quarrel is thus not with the ability of plans to set limits on the time in which claimants may seek review but with the lack of fair notice to claimants in Sun Life's chosen framework.

Our dissenting colleague acknowledges that there would be "some uncertainty" with respect to its approach but contends that this "uncertainty would be no different than that which exists regarding periods running from the date that a claim is denied." *Post* at 34. This is incorrect. Any uncertainty about the reasonableness and hence enforceability of contractual limitations periods that run from the date of claim denial is much less than that engendered by contractual accrual dates such as that of Sun Life, whose enforcement would depend in each case upon the amount of time needed to resolve a claim internally and could not be determined at the outset from plan documents.

Under Sun Life's approach, there would be compression of the stated limitations time in every case, some reasonable, and others not. For instance, here, the three-year limitations period shrunk to approximately two once

the plan completed its appeals. Every limitations period under Sun Life's approach would be significantly shortened by internal deliberations and appeals, and only some accrual provisions would be enforced. The case-by-case assessment of this compression that Sun Life advocates not only undermines the ERISA provisions noticed above but lays waste to limitations periods' critical purpose of providing potential plaintiffs with meaningful notice of the timeliness of their actions and providing potential defendants an equally clear sense of when the time on possible claims has run.[4]

D.

The arguments of our fine colleague in dissent do not change our view. Our colleague points in part to the existence of federal regulations that place outer limits on the amount of time that a plan may take in deciding a disability claim. The regulations limit the time that a plan may take in its initial consideration of a disability claim to

[4] Sun Life argues that a court should not enforce the three-year limitations period contained in its plan document without enforcing the accrual date to which the limitations period is tied, but even if the entire provision is deemed unenforceable, the limitations period remains three years. In the absence of a valid contractual provision governing limitations, we borrow a limitations period from the law of North Carolina, given the plan's statement that it "is delivered in North Carolina and subject to the laws of that jurisdiction." *See Dameron v. Sinai Hosp. of Baltimore, Inc.*, 815 F.2d 975, 981-82 (4th Cir. 1987) (applying state's statute of limitations for breach of contract). North Carolina law provides a three-year limitations period for breach of contract claims. *See* N.C. Gen. Stat. § 1-52(1) (2005). Sun Life issued a final denial of White's claim for disability benefits on March 28, 2001, and White filed suit less than three years later, on March 26, 2004. As a result, her civil action was timely.

45 days from the filing of a claim, with two 30-day extensions allowed when needed, 29 C.F.R. § 2560.503-1(f)(3) (2006), and they limit the time that a plan may take in considering an internal appeal to 45 days from the filing of the appeal, with the possibility of one extension, *id.* §§ 2560.503-1(i)(1)(i), 2560.503-1(i)(3)(i).

These time limits are long enough that depending on the length of the period in the plan, a plan's decision-making can eat up the entire limitations period. Moreover, plans will face incentives to delay in order to squeeze a participant's potential cause of action even when total expiration is not in question. On the theory that ERISA plans' limitations periods can be compared to the limitations periods for suits brought to set aside administrative decisions, which are ordinarily 30 or 60 days after a decision is rendered, *see Blue Cross & Blue Shield United of Wisc.,* 112 F.3d at 875, courts generally allow plans to impose limitations periods of several months in length, which could easily be consumed by a plan adhering to the periods prescribed under the regulations. But to repeat: even when a plan's limitations period cannot be entirely consumed by its internal decision-making, there remains the incentive to delay claims and cut short the period in which a claimant can bring an action, which will be present whether the plan is capable of eliminating the time available to its claimants or merely diminishing this time.

Moreover, the time limits prescribed in the regulations are themselves somewhat elastic and do not apply to all of the time that would be counted against a claimant. For instance, the regulations require that a disability plan provide at least 180 days to appeal an initial benefits determination, 29 C.F.R. §§ 2560.503-1(h)(4),

2560.503-1(h)(3)(i), but do not set a maximum time for appeals filing, although the pre-appeal period will be counted against a claimant who may require some time to obtain relevant or additional materials and present an appeal. In addition, by requesting more information for its determination, a plan can toll time constraints that the regulations impose on its consideration, even as the limitations period in the plan document would continue to run against the claimant. *Id.* § 2560.503-1(f)(4) (providing that when plan extends claims period to seek additional information needed to resolve claim, regulatory limitations period is tolled "from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information"). While the dissent engages in speculative calculations under the regulations, it seeks to soft-pedal the amount of time it might actually take a plaintiff to present a meaningful internal appeal. The regulations, which under Sun Life's scheme would all apply to post-accrual conduct, thus fail to alleviate the concerns we have expressed regarding incentive effects, constantly shifting time periods, the absence of fair notice to all parties, and the continual tension between internal appeals and judicial review. Perhaps recognizing that the regulations hardly resolve the problem, the appellant makes no reference to them in its extensive briefing.

The dissent's analysis of Sun Life's provision only deepens our concerns regarding the extent to which a "reasonableness" standard will leave plans and their participants at sea. The dissent applies in one fashion or another the same reasonableness analysis that Sun Life advocates. Our colleague says he would enforce Sun Life's provision to bar White's claims because it was reasonable

"as written," *see post* at 34, but underscores the facts of this case, *see post* at 25-26, 31 n.4 (emphasizing time this particular plaintiff had to file suit). If the dissent is implying that we are to interpret an accrual/limitations scheme such as Sun Life's as facially reasonable, that wholly fails to anticipate the length of other limitations periods and the length of other internal appeals processes. In short, the dissent fails to account for the compression of time that can shorten a stated limitations period to an "unreasonable" length. If the dissent is suggesting that the limitations period is reasonable as applied (Sun Life's position), that gives us little guidance beyond the facts of a particular case.

This confusion over whether courts should employ facial reasonableness tests or applied reasonableness tests required by proof of claim accrual provisions is not the only uncertainty created by the dissent. Beyond this, our colleague states that while White had less time available as a result of Sun Life's accrual provision than she would have had in the absence of the provision, the time left by the limitations period would still be "generous," *post* at 26, "ample," *post* at 32, and above all, "eminently reasonable," *post* at 29 – using the term "reasonable" or some variation on it more than twenty times throughout the opinion. These adjectives, however, provide no standards for determining the enforceability of proof of claim accrual provisions, beyond making plain the dissent's view that this particular accrual provision is a reasonable one, at least in this particular case. Indeed, the dissent, like Sun Life, cannot foreclose the possibility that the reasonableness of proof of claim accrual/limitations schemes will change over time: Any position that a limitations provision may still apply notwithstanding the shortened period left

by accrual provisions such as Sun Life's to file suit is but another way of saying that a single limitations period may sometimes be reasonable, and at other times not.

The dissent indicates that it is not troubled by the absence of standards or guidance in its approach. Future claimants and plans would thus be left to guess at what future courts will do when arguably reasonable limitations periods have arguably been unreasonably shortened by accrual provisions that consume time left claimants to file a civil suit. In this, the dissent misapprehends the function of rules. It is the purpose of a rule to anticipate the future and to provide the universe of possible parties with a clear standard to which they can conform their conduct.

In rejecting operation of the familiar federal accrual standard, the dissent does a disservice to all parties to an ERISA dispute. The irony is that the dissent would abandon a rules-based approach for case-by-case uncertainty in the context of accrual rules and limitations periods, where certainty is particularly desirable. *See Rotella v. Wood,* 528 U.S. 549, 555 (2000) (rejecting proposed accrual rule deemed "at odds with the basic policies of all limitations provisions: repose, elimination of stale claims, and certainty about a plaintiff's opportunity for recovery and a defendant's potential liabilities"). The irony is only multiplied when an undefined reasonableness standard is adopted in the context of a statute that places a premium on clear notice and comprehensible plan provisions. Our good colleague says plans must be interpreted "as written," *post* at 34, but the opposite result obtains under his standard where the interplay of accrual and limitations provisions and the tensions between internal and judicial review would only magnify the uncertainty that ERISA's

framework of written instruments with clear rules and plain notice was designed to prevent.

III.

Inasmuch as White's disability claim was not time-barred, we must proceed to the merits. The district court found that Sun Life's denial of benefits should be reviewed under an abuse of discretion standard because Sun Life's written plan gave the insurer discretionary authority to make disability determinations. *See Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan,* 201 F.3d 335, 341-42 (4th Cir. 2000) (holding that abuse of discretion review should apply to fiduciary's discretionary decision under ERISA). This standard requires that a decision be rationally supportable, which in turn requires that it be "the result of a deliberate, principled reasoning process" and "supported by substantial evidence." *Bernstein v. CapitalCare, Inc.,* 70 F.3d 783, 788 (4th Cir. 1995) (internal citation omitted). When, as here, a plan "both administers the plan and pays for benefits received by its members," so that a denial of benefits improves the insurer's bottom line, courts consider this as a factor in their review. *Id.* The district court granted summary judgment to White under this standard because it found disability benefits could not have reasonably been denied based upon the evidence.

White's disability claim came after she consulted with multiple specialists over the course of more than two years regarding severe and chronic pain in her lower back, buttocks, and legs. Surgery revealed that White's pain was no phantom syndrome: her "quite deformed" piriformis muscle was, as her surgeon put it, "tethering the peroneal

nerve division, which it had split, and was running in between." Dr. Kline, the surgeon whom both parties describe as a nationally recognized expert, warned that surgery would not necessarily end the patient's chronic pain. White chose to go forward, but she reported that while the severity of her pain ebbed and flowed following the operation, it never subsided.

The physicians who treated White before and after her surgery prescribed painkillers and muscle relaxants for symptoms they regarded as quite serious. Dr. Jones and Dr. Cain explained that White's extreme pain and the inability to sit at work were consequences of piriformis syndrome, unresolved after surgery. Dr. Jones wrote that he believed long-term disability was "probably the only option left to her," and explained his conclusion in a letter submitted to Sun Life. "Based on my experience and my treatment of Ms. White over the past two years, I do believe that she is disabled from performing any work on a continued and sustained basis due to her ongoing symptoms of chronic pain that have arisen from her peripheral nerve disorder," he wrote, adding that in his professional opinion, White had been "disabled from any occupation since at least February, 2000."

To be sure, ERISA does not impose a treating physician rule, under which a plan must credit the conclusions of those who examined or treated a patient over the conclusions of those who did not. *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994). But ERISA does require that in order to deny benefits, an insurer must present a basis "a reasoning mind would accept as sufficient" to support its decision. *LeFebre v. Westinghouse Elec. Corp.*, 747 F.2d 197, 208 (4th Cir. 1984) (internal citation omitted). Sun Life has not

done so. It first suggests that it justifiably denied benefits because the opinions of White's treating physicians conflicted. "[I]t is not an abuse of discretion for a plan fiduciary to deny . . . benefits where conflicting medical reports were presented," *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 606 (4th Cir. 1999), but Drs. Cain, Jones, and Kline did not submit conflicting reports. To the contrary, the reports indicate that the physicians collaborated by referring the patient to different doctors for the different aspects of her care, sharing their findings, and referencing each other's treatments and conclusions in a manner indicating a single treatment plan.

For instance, Dr. Jones referred White to Dr. Cain for management of her narcotic medications, and Dr. Cain routinely sent Dr. Jones the treatment reports from the resulting visits, noting in one report that she was also sending Dr. Jones a copy of the contract that White had signed. Dr. Jones then incorporated Dr. Cain's medication regimen in his own treatment reports. Similarly, Dr. Kline corresponded with Dr. Jones regarding White's treatment, and deferred to the medication regimen that Dr. Jones and Dr. Cain had established, writing on March 20, 2000, "I think pain management we will leave in your hands."

Sun Life disregards this mutual reliance and instead seeks to make much of several sentences taken out of context from Dr. Kline's March letter as establishing a disagreement among the physicians. Sun Life notes that Dr. Kline wrote that the "sciatic function" on his patient's right and left side was excellent. Nothing in Dr. Kline's letter, however, suggests that he believed this meant that White's pain was illusory. To the contrary, the sentence upon which Sun Life relies is the last in a long paragraph indicating that the patient suffered from serious ills,

namely lower-back, buttock, and leg pain and decreased range of motion. Dr. Kline's follow-up recommendations further indicate that he credited White's reports, in that the surgeon suggested exercises to ease her pain and did not recommend reducing White's intake of medications. Simply put, the remark on which Sun Life relies does not contradict Dr. Jones' description of total disability, or for that matter the rest of Dr. Kline's own report. *Cf. Myers v. Hercules, Inc.*, 253 F.3d 761, 766-67 (4th Cir. 2001) (rejecting denial of disability benefits based upon sentences in physician reports taken out of context, when reports as a whole supported finding of disability).

We also fail to find a basis for denying benefits in the other sentence in Dr. Kline's report upon which Sun Life relies. While Dr. Kline wrote that White stopped her work at Greer Laboratories "more because of familial problems and work problems than her disability and difficulty with her back and leg," this one sentence does not cast doubt upon her disability. Nothing in Dr. Kline's report suggests that the family conflicts and workplace difficulties were in any way independent of White's disability, and other reports explain all these problems as intertwined. Nor is the reason for White's departure relevant, so long as White was unable to perform her occupation – a fact supported by the abundant medical evidence, and upon which Dr. Kline did not express doubt. As the district court wrote, "Whether an employee is physically present at work, and whether she is able to perform the material duties of her occupation while there, are two separate issues. Dr. Kline's statement relates to the former, but disability under the Plan is premised on the latter."

In the absence of a conflict among White's physicians, Sun Life turns to two brief letters by Dr. Sarni, a

physician-consultant. Dr. Sarni never examined the patient nor did he at any time contact any of White's own doctors, two of whom were neurosurgeons whose speciality thus included White's syndrome, and all of whom had treated White for an extended period. While Dr. Sarni's two one-page letters expressed skepticism about White's disability, his conclusions lack support in White's medical records. Dr. Sarni summarized the patient's medication regimen and wrote that her "pain complaints are far out of proportion to the pathology described," adding, "There is no objective data at this point to support such significant impairments." This statement, however, is flatly incorrect. MRI and other tests were unable to pinpoint White's problem prior to surgery, but surgery revealed a severe physical deformity consistent with White's complaints of pain in the lower back, buttocks, and legs. White's surgeon warned that an operation would not necessarily solve White's problems and suggested that it might aggravate them. This finding of "severe abnormality" during major surgery provides objective evidence of White's impairments.

Furthermore, Dr. Sarni's suggestion that White's medications were excessive – based exclusively upon a review of White's medical records – lacks a basis in the records themselves. There is no doubt that White took painkillers. The file is replete, however, with physician statements that the doctors who examined and treated White believed these drugs were needed to ease her pain. *See, e.g.*, December 19, 2000 letter from Dr. Jones (stating that after surgery White "continued to require extremely large doses of narcotics for pain control" and describing White as "disabled from performing any work on a continued and sustained basis due to her ongoing symptoms of

chronic pain that have arisen from her peripheral nerve disorder"); November 22, 2000 report of Dr. Cain (stating patient's prescriptions "have been continually re-evaluated" and that the "patient appears to need this dosage in order to function"); April 17, 2000 report of Dr. Cain (stating "[c]hronic pain secondary to piriformis syndrome . . . appears to be slightly improved" after dosage adjustment and stating patient should "[c]ontinue current medications with no increase at this time"). In fact, Sun Life refers us to no statement from any of those treating White that the pain medication was unnecessary or that the pain itself was imagined.

The other evidence upon which Sun Life relies is equally unavailing. A vocational consultant who also did not examine White wrote that "[i]t is not clear to me what specifically precludes her from doing her sedentary job," but offered no reason why the constant pain and inability to sit described by White's various examining physicians did not fully support Dr. Jones' conclusion that his patient was unable to work. Moreover, contrary to Sun Life's suggestion, the fact that White suffered from depression does not indicate that her reports of chronic pain were an expression of psychiatric problems that White refused to treat. White's treating physicians repeatedly described the claimant's depression as a product of serious pain and inability to work or perform other activities, rather than the cause of those problems.

In sum, none of the material to which Sun Life points undercuts the account of prolonged disability presented consistently by White's medical records and her physicians' statements. White's pain was such that she elected to undergo major surgery whose outcome was uncertain in hope of finding some relief. The surgery revealed a

significant deformity. In the operation's aftermath, White continued to make multiple visits to multiple physicians for leg, lower-back, and buttock pain, which White complained prevented her from performing her job responsibilities and caused depression and family problems. The copious medical records from these visits provide no basis to conclude that White's pain was illusory or that she began suddenly to malinger in a company where she had risen through the ranks for well over a decade. Because Sun Life appears to have "reached its decision only by misreading some evidence and by taking other bits of evidence out of context," *Myers,* 253 F.3d at 768, we cannot find its denial of benefits was supportable.

IV.

For the foregoing reasons, the judgment of the district court is

AFFIRMED.

WILKINS, Chief Judge, dissenting:

The plan states that "[n]o legal action may start . . . more than 3 years after the time Proof of Claim is required," which equated here to August 9, 2003. J.A. 636. Despite an uneventful administrative claim process, White failed to meet this deadline. Sun Life first denied White's claim on August 15, 2000 and then denied her appeal of that decision by letter dated March 28, 2001. At that point, White, who was represented by counsel, had no further administrative remedies to exhaust and was left with more than 28 months to decide whether to file a civil action. Yet, she did not bring the present action until March 26, 2004 – more than seven months too late.

Having failed to bring suit within the generous period that the plan allowed, White now attempts to avoid the clear application of the plan language. The majority allows White to do just that, refusing to enforce the plan terms and holding that the plan drafters were not authorized to require that civil actions be filed within three years of the date that a claimant's Proof of Claim was due. Because I believe the majority's refusal to enforce the plan as written is plainly unjustified, I respectfully dissent.

I.

A.

ERISA requires that any employee benefit plan be "established and maintained pursuant to a written instrument." 29 U.S.C.A. § 1102(a)(1) (West 1999). It also mandates that plan terms be enforced, expressly providing causes of action to compel enforcement of plan terms and to remedy failures to enforce plan terms. *See* 29 U.S.C.A. § 1104(a)(1)(D) (West 1999) (requiring plan fiduciaries to discharge their duties "in accordance with the documents and instruments governing the plan"); 29 U.S.C.A. § 1132(a)(1)(B) (West 1999) (allowing participants to pursue a civil action "to enforce [their] rights under the terms of the plan"); 29 U.S.C.A. § 1132(a)(3) (West 1999) (providing cause of action "to enjoin any act or practice which violates . . . the terms of the plan" or to obtain other equitable relief "to enforce . . . the terms of the plan"). Indeed, "one of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans." *United McGill Corp. v. Stinnett*, 154 F.3d 168, 172 (4th Cir. 1998). For this reason, "the plain language of an ERISA plan must be enforced in accordance with its literal and natural meaning." *Id.* (internal quotation marks omitted).

Congress intended for courts to develop federal common law regarding ERISA to supplement its statutory provisions. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 56 (1987). However, this authority is limited to circumstances in which it is "necessary to fill in interstitially or otherwise effectuate the ERISA statutory pattern enacted in the large by Congress." *United McGill Corp.,* 154 F.3d at 171 (internal quotation marks & alteration omitted). Thus, "resort to federal common law generally is inappropriate when its application would conflict with the statutory provisions of ERISA . . . or threaten to override the explicit terms of an established ERISA benefit plan." *Id.* (internal quotation marks & alteration omitted). The majority's resort to federal common law here is clearly inappropriate for both reasons.

White's suit seeks benefits under an employee benefit plan pursuant to ERISA, *see* 29 U.S.C.A. § 1132(a)(1)(B). ERISA does not contain an express limitations period applicable to causes of action under this section. Thus, for default rules, courts have looked to state law regarding the length of limitations periods, *see Wilson v. Garcia,* 471 U.S. 261, 266-67 (1985), while holding that federal law governs the date when the limitations period commences, *see Rawlings v. Ray,* 312 U.S. 96, 98 (1941). Notwithstanding the existence of these default rules,

> it is well established that, in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period.

Order of United Commercial Travelers v. Wolfe, 331 U.S. 586, 608 (1947).

The *Wolfe* rule clearly applies to an ERISA plan, which, after all, "is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire." *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998). Although such contracts are not negotiated individually with employees, employee benefits comprise part of an employee's compensation package, and companies that erect unreasonable barriers to their employees' receipt of benefits can hurt themselves in competing for employees.[1] *See Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 874 (7th Cir. 1997).

The plan here states in no uncertain terms that "[n]o legal action may start . . . more than 3 years after the time Proof of Claim is required." J.A. 636. The plan provides that Proof of Claim was required "no later than 90 days after the end of the Elimination Period." *Id.* at 638. The "Elimination Period" is defined as "a period of continuous days of Total or Partial Disability for which no LTD Benefit is payable." *Id.* at 612. Under the plan terms, the "Elimination Period" was 90 days and "beg[an] on the first day of Total or Partial Disability." *Id.* at 605, 612. White alleged in her complaint that her first day of "Total Disability" was February 11, 2000. Thus, her Elimination Period expired on May 11, 2000, and her Proof of Claim

[1] Additionally, Congress' decision not to include a limitations period in the applicable statute specifically demonstrates a willingness to accept reasonable agreed-upon limitations periods. *See Taylor v. W. & S. Life Ins. Co.*, 966 F.2d 1188, 1205 (7th Cir. 1992).

was due on August 9, 2000.[2] The terms of the plan therefore required that any suit based on the facts before us be filed on or before August 9, 2003. On that basis, the limitations period contained in the plan must be enforced unless controlling law prohibits modification of the default rule or the period provided in the plan is unreasonable. Neither of these circumstances pertains here.

First, no controlling law prohibits adoption of the limitations period specified in the plan. As the majority observes, under the general federal rule, a cause of action under § 1132(a)(1)(B) accrues when a plan administrator formally denies a claim, *see Rodriguez v. MEBA Pension Trust*, 872 F.2d 69, 72 (4th Cir. 1989).[3] *See ante*, at 9. But,

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[2] White argues that Proof of Claim was actually due one year and 90 days from the end of the Elimination Period. That is incorrect. The plan states that for long term disability,

> proof of claim must be given to Sun Life no later than 90 days after the end of the Elimination Period.
>
> If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless the individual is legally incompetent.

Id. at 638. Here, it clearly was possible for White to give Proof of Claim within the 90 days after the end of the Elimination Period, as she in fact did so.

White also argues that her suit was timely filed because North Carolina General Statutes § 58-51-15(a)(7) (2005) provides that a proof of loss is not due until "180 days after the termination of the period for which the insurer is liable." That statutory provision is plainly inapplicable here as it concerns claims for which the insurer has determined there is a qualifying disability that would entitle the claimant to "periodic payment[s] contingent upon continuing loss." N.C. Gen. Stat. § 58-51-15(a)(7).

[3] While *Rodriguez* dictates when the cause of action arises, the Supreme Court has recognized that the event that gives a party the

(Continued on following page)

a federal rule concerning when a limitations period begins *in the absence of an agreement to adopt a shorter period* certainly is not a rule prohibiting adoption of a shorter period. *See Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program,* 222 F.3d 643, 650 (9th Cir. 2000) (en banc) (holding that even though federal law provided accrual date for § 1132(a)(1)(B) cause of action, whether separate limitations period provided in the plan barred plaintiff's action presented a separate question); *cf. Harbor Ct. Assocs. v. Leo A. Daly Co.,* 179 F.3d 147, 150-51 (4th Cir. 1999) (affirming enforcement of provision contracting around Maryland's default rule setting the date on which the limitations period would commence "[i]n light of [Maryland's] established judicial commitment to protecting individuals' efforts to structure their own affairs through contract"). Indeed, the *Wolfe* rule presumes that a default limitations period exists and provides that the parties can agree to a shorter period as long as it is reasonable.

Second, this limitations period was eminently reasonable. Nowhere in the record is there any suggestion that the limitations period was "a subterfuge to prevent lawsuits." *Northlake Reg'l Med. Ctr.,* 160 F.3d at 1304. Indeed, the limitations period was the very one that North Carolina and the vast majority of other states require be included in insurance policies like the one at issue here, *see* N.C. Gen. Stat. § 58-51-15(a)(11) (2005); *Wetzel,* 222 F.3d at 647 n.5 (listing states). It is one that at least two circuits have held to be reasonable. *See Doe,* 112 F.3d at

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right to bring suit need not be the same as the event that commences the running of a limitations period. *See Reiter v. Cooper,* 507 U.S. 258, 267 (1993).

874-75 (holding on facts essentially identical to those of the present case that plan limitations period was reasonable); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763, 764 (8th Cir. 1997) (holding that limitations period identical to that at issue here was reasonable). Tying the limitations period to the date on which proof of claim is due serves the important function of ensuring that a civil action is not too remote in time from the events giving rise to the plaintiff's claim. *See Mo., Kan. & Tex. Ry. Co. v. Harriman Bros.*, 227 U.S. 657, 672 (1913) (explaining that the purpose of a limitations period is to avoid a loss of evidence as the result of the passage of time); *ante,* at 16 ("Plans may legitimately wish to avoid extended limitations periods, because the disability status of a particular plaintiff may shift significantly over time, and because both the interests of claimants and a plan's own accounting mechanisms may be served by prompt resolution of claims.").

Although the period here could commence before a claim was formally denied, the three-year period was easily sufficient to preserve the claimant's rights considering the nature of a § 1132(a)(1)(B) suit:

> A suit under ERISA, following as it does upon the completion of an ERISA-required internal appeals process, is the equivalent of a suit to set aside an administrative decision, and ordinarily no more than 30 or 60 days is allowed within which to file such a suit. Like a suit to challenge an administrative decision, a suit under ERISA is a review proceeding, not an evidentiary proceeding. It is like an appeal, which in the federal courts must be filed within 10, 30, or 60 days of the judgment appealed from, depending on the

> nature of the litigation, rather than like an original lawsuit.

Doe, 112 F.3d at 875 (citations omitted); *see also Northlake Reg'l Med. Ctr.,* 160 F.3d at 1304 (enforcing limitations period of 90 days from denial of claim). The Department of Labor regulations applicable to the plan here require that a plan administrator notify a claimant of a denial of benefits within a reasonable period not to exceed 45 days after receipt of the claim. *See* 29 C.F.R. § 2560.503-1(f)(3) (2006). In certain circumstances, this period may be extended up to 60 additional days. *See id.* And, if the plan administrator determines that additional information is needed to resolve the claim, the time the claimant takes to produce the information is not counted toward the administrator's time limitations. *See* 29 C.F.R. § 2560-503-1(f)(4) (2006). If a claimant seeks internal review of the plan administrator's decision, the plan must notify a claimant of its determination within a reasonable time period not to exceed 45 days, with the possibility of an extension of up to 45 additional days. *See* 29 C.F.R. § 2560.503-1(i)(3) (2006). If the plan fails to make a decision within these deadlines, administrative remedies will be considered to be exhausted, and a claimant is entitled to file suit. *See* 29 C.F.R. § 2560.503-1(*l*) (2006). These time limitations ensure that even if a plan had obtained all possible extensions, it could take only 195 days of the three-year (1,095-day) limitations period. Thus, even under this extreme scenario, if a claimant spent six months responding to requests for additional information and another six months preparing an administrative appeal, she would still have almost a year and a half to decide whether to initiate a civil action. This is far more than the 30 or 60 days that would be sufficient for such a decision. *See Doe,* 112 F.3d at 875. Accordingly, the three-year time period is

not only more than sufficient to eliminate any significant possibility that a claimant could be disadvantaged; it likely leaves claimants with *much* more than 30 or 60 days after the claim is denied in which to bring suit.[4] Thus, the period was clearly reasonable.

B.

The majority concludes that although parties may agree to modify the length of a limitations period, they may not reject the federal default rule that the period begins when the claim is denied. *See ante,* at 11 (holding that the plan drafters may not provide that the limitations period can commence before administrative remedies have been exhausted because they "cannot write over the constraints established by federal law"). This is plainly incorrect. *Wolfe* allows parties to a contract to limit "the time for bringing an action" so long as the agreed upon period is reasonable. *Wolfe,* 331 U.S. at 608. Shortening the length of the default limitations period is only one way to limit the time for bringing an action. Setting a date earlier than the default date for commencement of the period is another. *See, e.g., Harbor Ct. Assocs.,* 179 F.3d at 150-51. Moreover, as noted above, tying the limitations period to the date that Proof of Claim was due – as opposed to beginning the period only when a claim is denied – has the perfectly rational purpose of ensuring that no

[4] In fact, that was the case with White. Sun Life first denied White's claim on August 15, 2000. It then denied her appeal of that decision by letter dated March 28, 2001, leaving White with no further administrative remedies to exhaust. White, who was represented by counsel, then had more than *28 months* within which to file an action in district court.

suit is too remote in time from the events giving rise to the claim. *See Harriman Bros.*, 227 U.S. at 672. The *Wolfe* rule and the freedom-of-contract principles underlying it clearly allow such a shortening of the limitations period to achieve this goal.

The majority also concludes that federal common law prohibits the adoption of the limitation period included in the plan because it would undercut the right to bring a § 1132(a)(1)(B) action. *See ante,* at 12 (holding that the "interlocking remedial structure [between administrative and judicial review] does not permit an ERISA plan to start the clock ticking on civil claims while the plan is still considering internal appeals"). The majority notes that with the limitations period in the plan, the clock can begin running before a claimant is entitled to file suit, thereby either reducing the time she has to bring suit or eliminating it altogether. *See id.* at 12. The majority also submits that such periods give plan administrators a motive to delay denying claims so as to reduce the time that plaintiffs have to bring suit. *See id.*

I believe the majority's concerns and its invocation of federal common law are without basis and certainly do not justify a refusal to enforce the plan terms. As I have explained, the three-year period is well-designed to leave a claimant with ample time to decide whether to file a civil action. Further, the fact that the regulations allow a plan administrator to spend no more than *195 days* deciding a claim and administrative appeal eliminates any significant possibility that a devious plan administrator could believe he could run out the three-year clock on a claimant before the claimant could sue. The presence of the clearly stated period serves to notify the parties from the very beginning of the process of the date by which a civil suit

must be initiated. There is simply no reason to believe that diligent claimants under this plan would have any trouble protecting their rights, and the majority does not contend otherwise.

Regardless of whether we might identify policy reasons why the default period would be preferable, it is for the plan drafter, not this court, to determine the plan terms. *See Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003) ("[E]mployers have large leeway to design . . . plans as they see fit."); *Gayle v. UPS,* 401 F.3d 222, 228 (4th Cir. 2005) (noting "the well-established principle that plans can craft their governing principles as they think best"); *cf. Kress v. Food Employers Labor Relations Ass'n,* 391 F.3d 563, 570 (4th Cir. 2004) (rejecting argument that plan term requiring attorneys' fees to be subrogated to plan reimbursement should not be enforced because it would discourage litigation). Despite the majority's statement that it "reaffirm[s]" that principle, *ante,* at 10, I believe its decision clearly undermines it.

The majority concludes that its resort to federal common law to defeat the plain language of the plan is justified because enforcement of the limitations period would "immerse[] federal courts in a federal common law enterprise that would undermine the ERISA framework." *Id.* at 15. The "enterprise" that the majority refers to is determining whether the amount of time a claimant actually has after a denial to file a civil action is "reasonable," so that the plan period may be enforced under *Wolfe. See id.* The majority similarly concludes that refusing to enforce the limitations period plainly provided for in the plan is necessary to eliminate the uncertainty that could exist regarding whether the time a claimant has left to file after a claim is denied is reasonable. *See id.* at 15-17. But,

with all due respect to the majority, it is only the majority's departure from the plain language of the plan that immerses the court in federal common law and creates uncertainty regarding plan terms.

The majority recognizes that despite the uncertainty regarding what limitations period length will be held to be reasonable under *Wolfe*, "ERISA generally affords plans the flexibility to set limitations periods." *Id.* at 16. The majority concludes, though, that the uncertainty rises to an unacceptable level when limitations periods run from the date of the claim because determination of whether the period is reasonable depends "in each case upon the amount of time needed to resolve a claim internally" and thus "could not be determined at the outset from plan documents." *Id.* at 17; *see id.* at 12-15. However, the majority never explains why it believes that the reasonableness or unreasonableness of a plan term could be altered by such subsequent events, and I certainly do not believe that it could. We should judge the reasonableness of a limitations period that runs from the date proof of claim is due as we judge any other limitations period, by determining the reasonableness of the term as written. While there would be, of course, some uncertainty regarding what we would hold to be the shortest reasonable period, that uncertainty would be no different than that which exists regarding periods running from the date that a claim is denied. In contrast, the vague "tension" that the majority relies on here to defeat the plain terms of the plan surely will give rise to much future litigation concerning what other plan terms are in "tension" with ERISA policies such that they may not be enforced, necessitating the development of much more extensive federal common law on the subject. *Id.* at 12.

Similarly, it is only the majority's refusal to enforce *the clear plan terms that fails to promote proper notice to* the parties. *See United McGill Corp.*, 154 F.3d at 172 (explaining that "the plain language of an ERISA plan must be enforced" and that "one of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans"). From the time that White filed her administrative claim here, the date by which she was required to file a civil action was set at August 9, 2003. With all the majority's discussion of "providing potential plaintiffs with meaningful notice of the timeliness of their actions and providing potential defendants an equally clear sense of when the time on possible claims has run," *ante,* at 17, it is the majority that pulls the rug out from under the parties at this late stage of the litigation by refusing to enforce the plan as written. By refusing to enforce the limitations period clearly provided in the plan when that period is well designed to serve the interests underlying statutes of limitations, the majority will also leave future claimants and plan administrators under a variety of plans wondering which plan provisions this court will refuse to apply next.

C.

It bears noting that the Seventh Circuit, in a thorough and well-reasoned opinion by then-Chief Judge Posner, enforced the very limitations period at issue here. *See Doe,* 112 F.3d at 872-73, 875. The majority brushes *Doe* aside, stating that while it "enforced a contractual accrual date, the focus . . . was on plans' freedom to set limitations periods, not accrual dates." *Ante,* at 16. This characterization is simply incorrect. In applying the *Wolfe* reasonableness rule, *Doe* considered the appropriateness of the

"limitations *period*," *Doe*, 112 F.3d at 873 (emphasis in original), which it correctly understood to include the event that commences the period as well as the length of the period. In this regard, *Doe* clearly considered the fact that the limitations period commenced when proof of claim is due and that the resulting period could theoretically be compressed or eliminated if the plan's resolution of the claim took a very long time. *See id.* Even considering that the length of the period would vary depending upon the time the plan takes to deny the claim, *Doe* found the period to be "reasonable in general and in th[at] case" in light of the fact that "a suit under ERISA is a review proceeding, not an evidentiary proceeding," and thus, "is like an appeal, which in the federal courts must be filed within 10, 30, or 60 days of the judgment appealed from." *Id.* at 875; *accord Blaske*, 131 F.3d at 764 (holding an identical limitations period to be reasonable).

On the other hand, the two contrary decisions cited by the majority are wholly unpersuasive. *See ante*, at 16. In refusing to enforce plan terms regarding when the applicable limitations period begins, both decisions simply rely on the federal default rule that ERISA claims accrue when a claim for benefits has been denied, without so much as discussing whether the *Wolfe* rule would allow the plan to adopt a reasonable shorter period. *See Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520-21 (3d Cir. 2007); *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993). It is therefore not surprising that the majority makes only cursory mention of these decisions. *See ante*, at 16.

II.

In sum, the ERISA plan before us plainly requires that any civil action be brought within three years of the date White's Proof of Claim was due. Because no law prevents the plan from adopting a limitations period shorter than the default period, Supreme Court precedent requires that the plan period be enforced so long as it is reasonable. The period here was eminently reasonable – generous even – and well constructed to prevent a suit too temporally removed from the events underlying it. That the majority refuses to enforce it is troubling and will no doubt leave plan administrators and participants in this circuit guessing which plan term this court will next refuse to enforce on the basis that it "creates tension" with ERISA policies. *Id.* at 12.

I would reverse the judgment to White and remand for entry of judgment in favor of Sun Life. I respectfully dissent from the majority's contrary decision.

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE WESTERN DISTRICT OF NORTH CAROLINA ASHEVILLE DIVISION

CIVIL NO. 1:04CV80

MARGARET T. WHITE, **Plaintiff,** **vs.** **SUN LIFE ASSURANCE COMPANY OF CANADA; GREER LABORATORIES, INC; GREER LABORATORIES, INC. EMPLOYEE LONG TERM DISABILITY PLAN; PLAN ADMINISTRATOR OF THE GREER LABORATORIES, INC. LONG TERM DISABILITY PLAN,** **Defendants.**	**MEMORANDUM AND ORDER** (Filed Aug. 11, 2005

THIS MATTER is before the Court on the Plaintiff's objections to the Magistrate Judge's Memorandum and Recommendation converting the Defendant Sun Life Assurance Company of Canada's motion to dismiss to a motion for judgment on the pleadings, and granting the motion.

I. FACTUAL AND PROCEDURAL HISTORY

On March 26, 2004, the Plaintiff filed this action in the General Court of Justice, Superior Court Division of Burke County, North Carolina, asserting against the Defendant Sun Life Assurance Company of Canada ("the

Defendant" or "Sun Life") state law claims for breach of contract, breach of duty of good faith and fair dealing, and unfair and deceptive trade practices, and "alternative" federal claims for benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plaintiff also asserted an ERISA penalty claim against the other Defendants for the failure to provide her with plan documents. The matter was removed to this Court on May 5, 2004, based on federal question jurisdiction over the Plaintiff's ERISA claims.

On November 1, 2004, Sun Life filed a motion to dismiss, arguing that the Plaintiff's state law claims were preempted by ERISA and the ERISA claim was untimely under the statute of limitations period and accrual date as provided by the provisions of the plan documents. The Plaintiff filed a timely response to the motion to dismiss, and Sun Life filed a reply. On January 7, 2005, United State Magistrate Judge Dennis Howell entered a Memorandum and Recommendation, converting Sun Life's motion to dismiss to a motion for judgment on the pleadings, and granting the motion. The Plaintiff filed her objections to the Magistrate's Memorandum and Recommendation on January 20, 2005.

II. STANDARD OF REVIEW

A district court is to conduct a *de novo* review of those portions of a Magistrate Judge's memorandum and recommendation to which specific objections by a party have been made. *Strawbridge v. Sugar Mountain Resort, Inc.*, 243 F.Supp.2d 472, 475 (W.D.N.C.2003). The Court will not address a party's general objections to a memorandum and recommendation because such objections have "'the same

effect as would a failure to object . . . making the initial reference to the magistrate useless.'" *Id.* (quoting *Howard v. Sec'y of HHS,* 932 F.2d 505, 509 (6th Cir.1991)). The Court will also carefully review all other portions of the memorandum and recommendation. *Id.*

The Plaintiff has specifically objected to the Magistrate Judge's recommendation that judgment on the pleadings be granted in favor of Sun Life on the grounds that the Plaintiff failed to file the claim within the time limits provided by the policy. A motion for judgment on the pleadings should only be granted where "accepting all well pleaded allegations in the [non-moving party's pleadings] as true and drawing all reasonable factual inferences from those facts in [that party's] favor, it appears certain that the [non-moving party] cannot prove any set of facts in support of [her] claim entitling [her] to relief." *Volvo Trademark Holding Aktiebolaget v. CLM Equip. Co., Inc.,* 236 F.Supp.2d 536, 540 (W.D.N.C.2002), *aff'd in part, vacated in part on other grounds,* 386 F.3d 581 (4th Cir.2004) (quoting *Edwards v. City of Goldsboro,* 178 F.3d 231, 243 (4th Cir.1999)); *United States v. 328 Pounds More or Less, of Wild American Ginseng,* 347 F.Supp.2d 241, 244 (W.D.N.C.2004).

III. DISCUSSION

The issue before the Court is whether the accrual date of the statute of limitations for an ERISA action may be set by the terms of a policy. ERISA does not articulate a statute of limitations period or accrual date, except for breach of fiduciary duty claims. *Shofer v. Hack Co.,* 970 F.2d 1316, 1319 (4th Cir.1992). In determining the appropriate statute of limitations period for other claims, a

court is to borrow the limitations period from the most analogous claim under state law.[1] *Id.* Furthermore, contractual agreed upon limitation periods, which may differ from analogous state law limitation periods, are permitted where reasonable. *Koonan v. Blue Cross & Blue Shield of Virginia,* 802 F.Supp. 1424 (E.D.Va.1992). Therefore, a provision in an ERISA policy setting a statute of limitations period is enforceable, as long as it is reasonable.

In contrast, the accrual date of the limitations period is generally determined with regard to federal law. *Bryant v. Food Lion Inc.,* 100 F.Supp.2d 346, 377 n. 140 (D.S.C.2000), *aff'd,* 8 Fed. Appx. 194 (4th Cir.2001) ("Federal law determines the accrual date of a statute of limitations in ERISA cases even though state law is the basis for the statute of limitations applied.") (citing *Michigan United Food & Com. Workers v. Muir Co.,* 992 F.2d 594, 597 (6th Cir.1993)). The Fourth Circuit has held that "[a]n ERISA cause of action does not accrue until a claim for benefits has been made and formally denied." *Rodriguez v. MEBA Pension Trust,* 872 F.2d 69, 72 (4th Cir.1989). Sun Life argues that despite this rule, contractually agreed upon accrual dates, like limitations periods, are permissible where reasonable.[2] Therefore, the Defendant argues that a provision in an ERISA plan setting the accrual date for the

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[1] The Fourth Circuit has held that for ERISA actions regarding a denial of benefits, the most analogous claim under state law is breach of contract. Breach of contract claims under North Carolina law have a three year statute of limitations. Regardless, the ERISA plan in the case at bar has also articulated a limitations period of three years, which the Court deems reasonable, and thus, will be applied.

[2] In support, Sun Life observes that the ERISA plan in *Rodriguez* did not articulate an accrual date, and therefore, the issue was not before the Fourth Circuit at that time.

statute of limitations prior to the date the participant's claim was formally denied, is enforceable if reasonable.

To the Court's knowledge, this specific issue has not been addressed by the Fourth Circuit. The Court notes that the Fourth Circuit has, in one case, implicitly approved of and used a contractually set accrual date in calculating the appropriate statute of limitations for an ERISA claim.[3] *See, Yarde v. Pan Am. Life Ins. Co.*, 67 F.3d 298 (table), 1995 WL 539736, at *7 (4th Cir.1995). However, the Court believes *Yarde* is not dispositive of this issue. In *Yarde,* the plaintiff did not argue that a different accrual date should be used, and therefore, the Circuit did not consider the issue on appeal. Furthermore, the Circuit ultimately determined that the plaintiff's action was timely filed using the earlier accrual date included in the plan, and thus the action would also have been timely filed had the later date benefits were formally denied been used. *Id.,* at *7-8. Given that no discussion of the proper accrual date was given by the Court and the issue did not affect the outcome of the case, this Court does not believe

[3] Sun Life has also presented to the Court, in a notice of subsequently decided authority, the Fourth Circuit's recent opinion in *Gayle v. United Parcel Service, Inc.*, 401 F.3d 222 (4th Cir.2005). In *Gayle,* the Fourth Circuit enforced contractually agreed upon accrual dates and periods within which a plan participant may commence an *internal* appeal with the provider regarding a benefit determination. *Id.*, at 226. The Court determined that under federal regulations, plan providers were authorized to establish and limit periods within which internal administrative appeals may be pursued. *Id.* The Court also addressed circumstances justifying the "equitable tolling" of limitation periods. *Id.*, at 228. However, the Court did not address the propriety of contractually agreed upon accrual dates for filing legal claims in state or federal court and, therefore, the decision is not controlling on the issue before the Court.

that *Yarde* stands for the proposition that contractually set accrual dates are permissible.

Similarly, other cases presented by Sun Life in which courts have used contractually set accrual dates, are unpersuasive. In each of the cases, the issue of whether the parties may contractually set an accrual date other than the date benefits were formally denied was not before the court. *See Clark v. NBD Bank,* 3 Fed. Appx. 500 (6th Cir.2001); *Moore v. Berg Enter., Inc.,* 201 F.3d 448 (table), 1999 WL 1063823 (10th Cir.1999); *Doe v. Blue Cross v. Blue Shield United of Wisconsin,* 112 F.3d 869 (7th Cir.1997); *McDuffie v. Flowers Hospital, Inc.,* 2001 WL 102398 (S.D.Ala.2001), *aff'd,* 33 Fed. Appx. 991 (11th Cir.2002). Instead, each court, without discussion or consideration of an alternate accrual date and without noticeable objection by any of the plaintiffs, simply accepted the use of the contractually set accrual date in determining whether the claim before it was timely filed. The Court has been unable to find, and has not been presented with any case by the parties, in which the issue was specifically addressed by a court and that court subsequently found the contractually set accrual date was permissible. In contrast, the Court is aware of numerous district courts and one court of appeals which have explicitly examined the issue, and concluded that, regardless of the accrual date articulated by the plan, the proper accrual date for an ERISA action is the date on which benefits were formally denied. *See, e.g., Price v. Provident Life & Accident Ins. Co.,* 2 F.3d 986 (9th Cir.1993); *Lowry v. Aetna Life Ins. Co.,* 1996 WL 529211, at *4 (S.D.N.Y.1996); *de Coninck v. Provident Life & Accident Ins. Co.,* 747 F.Supp. 627 (D.Kan.1990).

The Court agrees with the reasoning of the latter decisions, and determines that the accrual date for the statute of limitations of an ERISA action is the date benefits are formally denied, regardless of plan provisions to the contrary. If the Court were to instead apply the accrual date found in the provisions of the plan, the Plaintiff here would have three years from the date the proof of loss was required to be filed to initiate her legal claim. Under well settled law, however, a plaintiff is not permitted to file a claim until she has exhausted all administrative remedies, *see Gayle, supra,* and a plaintiff will not be deemed to have exhausted all of her administrative remedies until the appeal of her initial benefit determination has been formally denied. *See Williams v. Ironworkers Local No. 16 Pension Fund,* 2005 WL 1076133 (D.Md.2005). Therefore, if the contractually set accrual date were applied, there would exist a period of time between the Plaintiff's filing of a proof of loss and the time in which her benefits are formally denied during which the statute of limitations is running, but she is unable to file a claim. The Court believes this particular application of contractually set accrual dates demonstrates the impropriety of the Defendant's argument. The use of contractually set accrual dates would compress the time period within which a plan participant may actually file a legal claim. This compression is also exacerbated given the complicated and time consuming nature of ERISA administrative appeals processes. *See, Lowry, supra* (noting any "delays in appealing to the insurer a denial of benefits would shorten the limitations period"). Though somewhat unlikely, if the period of time to exhaust administrative remedies was extremely protracted, using the contractually set accrual date could result in a complete loss of the ability to file a claim under the terms of the plan. *Id.*

In the same manner, the Court believes that permitting contractually set accrual dates also opens the process up to potential abuse by plan providers. Plan providers could intentionally set early accrual dates while delaying the formal denial of benefits, severely compressing the opportunity within which a beneficiary may file a suit regarding her benefits. *See Price, supra,* at 988 (noting that permitting contractually set accrual dates would "allow the insurer to simply bury a denial of coverage and wait for the statute of limitations to run.") *Lowry, supra* (noting an "insurer could delay denial of benefits and drastically reduce a beneficiary's time to bring suit").

Limiting a beneficiary's access to the courts and creating opportunities for abuse by plan providers in such a way is also inconsistent with Congress' expressed intentions in creating ERISA. ERISA was instead intended to "protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . [and provide] for appropriate remedies, sanctions, and ready access to courts." 29 U.S.C. § 1001(b); *see also, Darcangelo v. Verizon Communications, Inc.,* 292 F.3d 181, 190 (4th Cir.2002) (citations omitted). Congress also intended for ERISA to alleviate plan participants of procedural obstacles as would arise here. *Connors v. Hallmark & Son Coal Co.,* 935 F.2d 336, 343 (D.C.Cir.1991) (noting "Congress' intent in ERISA [is] to provide "broad remedies" and "to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective . . . recovery of benefits due to participants." (quoting S.Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), U.S. Code Cong. & Admin. News 1974, pp. 4639, 4871)); *Lowry, supra* (citing *Hallmark, supra*). The Court believes that contractually set accrual dates

would only create additional procedural obstacles preventing participants access to the courts.

The Court also believes this holding is consistent with the general rule which establishes that federal law determines when the statute of limitations period accrues. Under the general rule, the accrual date is the "point in time when the plaintiff knows or has reason to know of the injury which is the basis of [her] action." *Bireline v. Seagondollar,* 567 F.2d 260, 263 (4th Cir.1977). With regard to ERISA actions, the plan participant has not suffered an injury until she has exhausted her administrative appeals and has been formally denied benefits. *See Price, supra.* Until that point, if the plan provider pays the plan participant's claims in full, the participant will not have a legal claim against the provider.

Therefore, while the Court has great respect for freedom of contract, in ERISA cases such as the one at bar, the Court believes that the parties may not contractually set an accrual date for the statute of limitations other than the date benefits are formally denied to the plan participant. In this case, the Plaintiff filed her claims within three years of the date her benefits were formally denied. The Plaintiff's claims are, therefore, not time-barred, and Sun Life's motion to dismiss is denied.

Because the Court has determined that the Plaintiff's claims were timely, the Court need not address the Plaintiff's additional objections to the Magistrate Judge's memorandum and recommendation arguing the claims were timely under alternative grounds.

IV. ORDER

IT IS, THEREFORE, ORDERED that Defendant Sun Life's motion for judgment on the pleadings regarding Plaintiff's ERISA claims, on the grounds that said claims are untimely under the statute of limitations, is **DENIED**.

As stated in the Court's previous Order, the parties shall file their dispositive motions on or before 30 days from entry of this Order. **Order, filed May 31, 2005.** If a trial is necessary in this case, it will be scheduled during the Court's November 2005 mixed civil and criminal term beginning November 14, 2005.

IN THE DISTRICT COURT
OF THE UNITED STATES
FOR THE WESTERN DISTRICT
OF NORTH CAROLINA
ASHEVILLE DIVISION
1:04cv80

MARGARET T. WHITE, **Plaintiff,** **Vs.** **SUN LIFE ASSURANCE COMPANY OF CANADA; GREER LABORATORIES, INC.; GREER LABORATORIES, INC. EMPLOYEE LONG TERM DISABILITY PLAN; PLAN ADMINISTRATOR OF THE GREER LABORATORIES, INC. LONG TERM DISABILITY PLAN,** **Defendants.**	**MEMORANDUM AND RECOMMENDATION** (Filed Jan. 7, 2005)

THIS MATTER is before the court upon defendant Sun Life Assurance Company of Canada's (hereinafter "defendant") Motion to Dismiss. Having carefully considered defendant Sun Life Assurance Company of Canada's Motion to Dismiss and reviewed the pleadings, including plaintiff's response and defendant's reply, the court enters the following findings, conclusions, and Recommendations.

FINDINGS AND CONCLUSIONS

1. Defendant's Rule 12(b)(6) Motion is Not Timely

While not raised in plaintiff's response to defendant's Motion to Dismiss, it appears to the court from the face of the docket that defendant's Motion to Dismiss, citing Rule 12(b)(6), Federal Rules of Civil Procedure, is untimely as a matter of law. On June 1, 2004, defendant filed its Answer with this court and therein failed to assert a defense under Rule 12(b)(6). *See* Docket Entry 4. Because such Answer caused issues to join, the court entered a Pretrial Order and Case Management Plan on October 6, 2004. *See* Docket Entry 16. On November 1, 2004, defendant filed the instant Motion to Dismiss under Rule 12(b)(6). Rule 12(b)(6) provides, in pertinent part, as follows:

> Every defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third-party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion: (1) lack of jurisdiction over the subject matter, (2) lack of jurisdiction over the person, (3) improper venue, (4) insufficiency of process, (5) insufficiency of service of process, (6) failure to state a claim upon which relief can be granted, (7) failure to join a party under Rule 19. **A motion making any of these defenses shall be made before pleading if a further pleading is permitted.**

Fed. R. Civ. P. 12(b)(6) (emphasis added). Because defendant failed to assert such motion before filing a responsive pleading, here five months later, the Motion to Dismiss is untimely.

As a corollary to Rule 12(b)(6), an exception exists that saves an untimely Rule 12(b)(6) motion. Rule 12(h)(2) provides, in relevant part, as follows:

> defense of failure to state a claim upon which relief can be granted . . . may be made in any pleading permitted or ordered under Rule 7(a), or by motion for judgment on the pleadings, or at the trial on the merits.

Fed. R. Civ. P. 12(h)(2). Where a Rule 12(b)(6) motion is untimely, a court may convert it into one under Rule 12(c). *Savina v. Gebhart*, 497 F.Supp. 65, 68 (D.Md. 1980). Converted to a motion for judgment on the pleadings, Rule 12(c) provides:

> After the pleadings are closed but within such time as not to delay the trial, any party may move for judgment on the pleadings. If, on a motion for judgment on the pleadings, matters outside the pleadings are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

Fed. R. Civ. P. 12(c). The issue of whether matters have been presented outside of the pleadings requiring conversion to summary judgment is addressed *infra*.

II. The Missing Copy of the Plan as Exhibit A to Its Motion to Dismiss

The court has closely reviewed defendant's Answer, Motion to Dismiss, and Memorandum in Support, and can

find no Plan attached as Exhibit A. Inasmuch as plaintiff addressed the substance of the Plan in its response, the court has assumed that it was attached to plaintiff's service copy and that the missing document is a clerical error. To correct that error, counsel for defendant was contacted and asked to submit a copy of the Plan by facsimile and by way of a supplemental filing.

III. Procedural History and Factual Background

On March 26, 2004, plaintiff filed this action in the North Carolina General Court of Justice, Superior Court Division, Burke County, asserting state-law claims against defendant for breach of contract, breach of a duty of good faith and fair dealing, unfair and deceptive trade practices, and, in the alternative, a claim for benefits under the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA"). Plaintiff also alleged an additional claim against other defendants – the "ERISA Penalty Claim" – for alleged failure to provide her with plan documents. On May 4, 2004, all defendants timely removed this matter from state court to this court based on the presence of a federal question under ERISA.

The following facts have been drawn from the Complaint[1] and will be considered as true for the limited purpose of disposing of defendant's Motion to Dismiss, which the court has converted into a motion for judgment on the pleadings. Plaintiff was an employee of defendant Greer Laboratories, Inc. (hereinafter "Greer Labs") from 1984 through February 11, 2000. Beginning in 1997, plaintiff began experiencing back pain, underwent back

[1] Citations to paragraphs of the Complaint omitted for brevity.

surgery in 1999, and in 2000 resigned her position citing back pain as her reason for leaving. Immediately before resigning from Greer Labs, she served as the Vice President of Administration.

While employed with Greer Labs, plaintiff participated in the Greer Laboratories, Inc. Long Term Disability Plan (hereinafter "LTD Plan") and was enrolled in the LTD Plan at the time she left Greer Lab's employment. In essence, the LTD Plan provides monthly benefits to participants who are disabled and meet other criteria, all of which are defined by the LTD Plan.

After leaving Greer Labs, plaintiff filed a claim on May 5, 2000, which was denied. Plaintiff appealed the denial on October 12, 2000, and submitted additional medical information and arguments in support of her claim on December 28, 2000. The initial determination denying plaintiff's claim was affirmed March 28, 2001. Plaintiff filed this action on March 26, 2004.

Defendant contends that the state-law claims should be dismissed as preempted by ERISA and that the ERISA action is time barred based on a contractual three-year period of limitation based on a contractual accrual date, all provided in the LTD Plan. Defendant asserts that the limitations period ran approximately seven months prior to the initiation of the action.

Plaintiff contends that it is improper under Rule 12, Federal Rules of Civil Procedure, and therefore improper under Rule 12(c), for this court to consider the text of the Plan, which plaintiff did not attach to her Complaint, but which defendant submitted in support of its Motion to Dismiss. Further, plaintiff argues that it is improper for an ERISA plan to contractually alter an accrual date

because when a federal action accrues is a matter of federal law.

IV. Standard

Defendant has moved for dismissal pursuant to Rule 12(b) contending that the state-law claims against it are preempted and that the federal claim is time barred. The court has converted this motion to one for judgment on the pleadings under Rule 12(c). The standard for ruling on a motion for judgment on the pleadings is well settled. The moving party has the burden of clearly establishing that there are no material issues of fact in dispute and that it is entitled to judgment as a matter of law. *King v. Gemini Food Services, Inc.*, 438 F. Supp. 964 (E.D. Va. 1976), *aff'd*, 562 F.2d 297 (4th Cir. 1977), *cert. denied*, 434 U.S. 1065 (1978). All well-pleaded allegations of the complaint are taken as true and admitted. *Felder v. Great American Ins. Co.*, 260 F. Supp. 575 (D.S.C. 1966). In *Madonna v. United States*, 878 F.2d 62 (2d Cir. 1989), the appellate court held:

> [In] evaluating a Rule 12(c) motion, the court must view the pleadings in the light most favorable to, and draw all reasonable inferences in favor of, the nonmoving party. The court must also take "the well-pleaded material facts alleged in the complaint . . . as admitted," and may not dismiss the complaint "unless it appears beyond a doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief," *Conley v. Gibson*, 355 U.S. 41, 45-46, 2 L. Ed. 2d 80, 78 S. Ct. 99 (1957).

Id. (citations omitted). A motion for judgment on the pleadings is well taken where there is no material issue of

fact and the movant is entitled to a judgment as a matter of law. *Bruce v. Riddle*, 631 F.2d 272 (4th Cir. 1980). For the limited purpose of ruling on defendant's motion, the court has accepted as true the facts alleged by plaintiff in the Complaint and has viewed them in a light most favorable to plaintiff.

V. Preemption of State Law Claim

Defendant first contends that all state-law claims are preempted under ERISA. The United States Supreme Court has determined that preemption may occur in the following three situations:

(1) express preemption, where Congress states its intent to do so;

(2) inferred preemption, where Congress has so pervasively regulated the field that there is no room left for states to supplement federal law; and

(3) conflict preemption, where state law is in actual conflict with federal law.

California Fed. Sav. and Loan Assn. v. Guerra, 479 U.S. 272 (1987). In *Griggs v. DuPont*, 237 F.3d 371 (4th Cir. 2001), the Court of Appeals for the Fourth Circuit found that to determine whether ERISA preempts state common-law claims, courts are required to look to the four corners of the state-law complaint for a factual determination of the nature of a plaintiff's claim, rather than any label the plaintiff may have put on their claim. *Id.*, at 379.

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the Supreme Court held that a state cause of action

"'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. Preemption applies even where such a law "'is not specifically designed to affect such plans, or the effect is only indirect.'" *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129-30 (1992) (*quoting Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 139 (1990)). What must be present is a nexus between the claim made and the plan, and that nexus must not be too tangential. *Smith v. Dunham-Bush, Inc.,* 959 F.2d 66, 9 (2nd Cir. 1992).

Under ERISA, a state-law claim is preempted where: (1) the claim is premised upon the existence of a plan, and plaintiff must plead and prove a plan exists in order to prevail; or (2) the claim directly conflicts with an ERISA cause of action. *Ingersol-Rand Co.*, at 140 & 142.

In order for plaintiff herein to prevail on any of her claims, she would have to prove that a plan exists, she is a participant in such plan, and she is entitled to benefits under the plan. *Griggs v. DuPont, supra* at 378. All of plaintiff's state-law claims have a nexus to the ERISA claim and must, therefore, be dismissed as preempted.

VI. Timeliness of Plaintiff's ERISA Claim

Defendant next contends that the remaining claim against it under ERISA is time barred due to the contractual three-year period of limitation and accrual date, all provided by the LTD Plan. In response, plaintiff first contends that it is inappropriate to consider this issue on a motion to dismiss, inasmuch as matters outside the pleadings have been submitted to the court, i.e., the LTD Plan documents. Plaintiff's argument is equally applicable

to a motion for judgment on the pleadings. Even if the issue could be considered, plaintiff argues, an ERISA plan cannot alter an accrual date because determination of when a federal cause of action accrues is a matter of federal law. The undersigned can find no support for either argument of plaintiff.

A. Consideration of the Plan

Turning first to the issue of whether it is proper to consider the text of the ERISA plan in a support of a motion to dismiss or motion for judgment on the pleadings, courts have held that as

> a general rule, in the context of a motion to dismiss under Rule 12(b), the court may not consider matters outside the pleadings without converting the motion to dismiss into a motion for summary judgment. *Gay v. Wall*, 761 F.2d 175, 178 (4th Cir. 1985). However, the court may consider dispositive documents that are either attached to, or referenced in, the complaint. *Moore v. Flagstar Bank, et al.*, 6 F.Supp.2d 496 (E.D. Va. 1997) (citing 5A Charles A. Wright and Arthur R. Miller, Federal Practice & Procedure § 1357 (1990)).

Hanover Ins. Co. v. Corrpro Companies, Inc. 312 F.Supp.2d 816, 820 (E.D. Va. 2004). In the context of considering plan documents in support of motions to dismiss in ERISA matters, one court noted that notwithstanding Mers' failure to attach a copy of the Plan to her Complaint, this Court properly considers the Plan's language and provisions in resolving Defendants' motion to dismiss:

> Although courts are generally not to consider documents outside the pleadings under Federal

> rule of Civil Procedure 12(b), Rule 10(c)provides that "[a] copy of any written instrument which is an exhibit to a pleading is apart thereof for all purposes." Fed. R. Civ. Pro. 1(c). Rule 10(c), which is permissive in nature, means that although a plaintiff is not obligated to attach documents to the complaint, "a defendant may introduce certain pertinent documents if the plaintiff failed to do so." *Venture Assocs. Corp. v. Zenith Data Systems Corp.*, 987 F.2d 429, 431 (7th Cir. 1993). A court may consider a document as a part of the pleadings if the plaintiff has referred to the document in his complaint and the document is central to the plaintiff's claim. *Id. Eret v. Continental Holding, Inc.*, 838 F. Supp. 358, 362 (N.D. Ill. 1993); see also *Marks v. CDW Computer Centers, Inc.*, 901 F. Supp. 1302, 1309-10 (N.D. Ill. 1995).

Mers v. Marriott Intern. Group Accidental Death and Dismemberment Plan, 1996 WL 219701, at 3 (N.D.Ill.1996).

In this case, review of the Complaint reveals that plaintiff has referred to the LTD Plan in numerous paragraphs. Without doubt, the LTD Plan is referenced by the Complaint and is "central to the plaintiff's claim" and is most appropriate for consideration without the requirement of conversion of this matter to one for summary judgment.

B. Timeliness of the Complaint

Turning to the LTD Plan, the plain language of the plan provides in pertinent part that "[n]o legal action may start . . . more than three years after the time Proof of Claim is require." LTD Plan, at 38. In turn, a "Proof of Claim" is due to be submitted "no later than 90 days after

the end of the Elimination Period," *id.*, at 40, which is also 90 days. *Id.*, at 6. According to the terms of the LTD Plan, plaintiff's action accrued 180 days after her employment at Greer Labs was terminated on February 11, 2000 (the date plaintiff contends her condition prohibited her from continuing her work), making August 9, 2000, the date of accrual.

Contractual limitations periods have long been held lawful as they are reasonable. *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 608 (1947). Clearly, a contractual three year limitation of actions is reasonable inasmuch as other courts have found 45 day, 90 day, and one year periods reasonable. *Davidson v. Wal-Mart Assoc. Health and Welfare Plan,* 305 F.Supp. 2d 1059 (S.D. Iowa 2004); *Northlake Reg'l Med. Ctr. V. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998); *Koonan v. Blue Cross & Blue Shield of Virginia,* 802 F.Supp. 1424 (E.D. Va. 1992).

The parties have, quite properly, focused on the issue of whether an accrual date can be determined contractually or whether the setting of an accrual date in ERISA plans is exclusively a matter of federal legislative or common law. In the context of ERISA, the Court of Appeals for the Fourth Circuit has held that

> [a]n ERISA cause of action does not accrue until a claim of benefits has been made and formally denied. To hold otherwise would require lay participants and beneficiaries to be constantly alert for "errors or abuse that might give rise to a claim and start the statute of limitations running." It also would burden the judicial system with multiple and premature actions.

Rodriguez v. MEBA Pension Trust, 872 F.2d 69, 72 (4th Cir. 1989) (citations omitted). In *Rodriguez*, however, no accrual date was provided in the ERISA plan.

While the parties are correct that the Fourth Circuit has yet to directly address the specific issue of whether contractually setting an accrual date is lawful under ERISA, the court's research reveals that the Court of Appeals for the Fourth Circuit has passed on and let stand a contractual accrual in an ERISA plan, which is strikingly similar to the contractual accrual and period of limitation at issue here:

> We are equally unpersuaded by Pan American's argument that Yarde failed to file suit in the South Carolina courts in a timely fashion. The insurer's Benefit Plan states that "[no action shall] be brought at all unless brought within three years from the expiration of the time within which proof of loss is required to be furnished."

Yarde v. Pan American Life Insurance Co., 67 F.3d 298 (Table), 1995 WL 539736, at 7 (4th Cir. 1995) (copy placed in case file) (*reversing in part Yarde v. Pan American Life Insurance Co.*, 840 F.Supp. 406 (D.S.C. 1994)). In *Yarde*, both the district and appeallate court used and implicitly approved the contractual accrual and limitation period in determining that Yarde had filed a timely civil action. While the appellate court's decision in *Yarde* is unpublished, it appears clear that neither the district nor the appellate court had any legal concern with running a period of limitations from a contractual accrual date as opposed to accrual created by federal common law. The court notes that the author of *Yarde*, the late Honorable

Samuel J. Ervin, III, Chief Judge of the United States Court of Appeals, was also on the earlier *Rodriguez* panel.

Beyond *Yarde*, the issue of contractual accrual in the context of ERISA appears, as the parties point out, unaddressed in the Fourth Circuit; however, the appellate court's implicit approval of contractual accrual in *Yarde* is consistent with a number of well reasoned decisions of other appeallate and district courts, which have found that accrual dates which run from the deadline for proof of loss to be both reasonable and enforceable. *See Doe v. Blue Cross Blue Shield United of Wisconsin*, 112 F.3d 869 (7th Cir. 1997); *Clark v. NBD Bank, N.A.*, 3 Fed. Appx. 500 (6th Cir. 2001); *Moore v. Berg Enters.*, 1999 U.S. App. Lexis 30481 (10th Cir. 1999); *McDuffie v. Flowers Hosp., Inc.*, 2001 U.S. Dist. Lexis 1182 (S.D. Ala. 2001). The undersigned finds that based on *Yarde* and the decisions of other circuits, contractual accrual is appropriate under ERISA where the date is reasonable. Here, the accrual date is 180 days from the date plaintiff contends her condition became disabling; it mirrors the accrual date used in standard contracts of insurance; and, coupled with a contractual three year period of limitation, provides the beneficiary of the policy with ample time to either protect and assert her rights herself or employ counsel. From the face of the plaintiff's Complaint, it is apparent that plaintiff failed to file this civil action within the time limitations provided by the policy.

C. Proposed Extended Filing Period

Plaintiff next argues that even if she missed the limitation period based on an August 9, 2000, accrual, her action should be deemed timely because the policy

provides an exception for extending the time "if it is not possible to give proof within these time limits, it must be given as soon as reasonably possible." Plaintiff's actual filing of her claim on May 5, 2000, belies her reliance on the plan's impossibility clause. Again, reference can be made to *Yarde* where plaintiff's failure to file a timely complaint was excusable, because the district court "properly interpreted the insurance policy as "provid[ing] for a reasonable period of time to furnish proof of loss when circumstances frustrate a claimant's efforts." *Yarde*, 1995 WL, at 8. In this case, not only was plaintiff able to submit a proof of loss within the time allowed, she was further able to supplement her claim and perfect an appeal of the initial denial, all within calendar year 2000.

D. Statutory Period for Submitting a Proof of Loss

Finally, plaintiff appears to argue that her suit was timely filed under a theory that Chapter 58-51-15(a)(7) of the North Carolina General Statutes provides that a proof of loss is not due until "90 days after the termination period for which the insurer is liable." Plaintiff's Response at 10 (quoting N.C. Gen. Stat. § 58-51-15(a)(7)).[2] This provision is facially inapplicable to plaintiff because she has never been determined to have a qualifying disability that would entitle her to "periodic payment[s] contingent upon continuing loss." Plaintiff's claim is not that defendant has cut off payments improperly, which is what the statute addresses, rather, her claim is that defendant

[2] Chapter 58-51-15(a)(7) was amended effective July 1, 2001, to increase the period from 90 days to 180 days. This claim precedes the effective date.

improperly denied liability for her claim in the first instance.

Under plaintiff's theory, the limitation on her action would not expire until the expiration date of the policy. Such a reading is well beyond the North Carolina statue, would render the contractual limitations meaningless, and would also render meaningless default accrual dates and limitation periods found at federal common law. The only reading of the state statute that is harmonious with federal law and common sense is that North Carolina's 90 day period (now 180 days) within which to file a claim, followed by what is best described as a rolling three year period of limitation under Chapter 58-51-15(a)(11), is contingent upon assumption of a liability by the insurer followed by the denial of a periodic payment to the insured based on that liability.

E. Equitable Tolling

Finally, the undersigned can find no basis for tolling, equitable or otherwise, inasmuch as plaintiff alleges at paragraph 28 of her Complaint that she was represented by counsel as early as October 2000 as to her claim for benefits. The undersigned finds that plaintiff's claims against this defendant are time barred, and will respectfully recommend to the district court that defendant's Motion to Dismiss, converted to a motion for judgment on the pleadings, be granted inasmuch as there are no material issues of fact and this defendant is entitled to judgment as a matter of law.

RECOMMENDATION

IT IS, THEREFORE, RESPECTFULLY RECOMMENDED that defendant Sun Life Assurance Company of Canada's Motion to Dismiss (#16) be converted to a motion for judgment on the pleadings, and that such motion be **ALLOWED**.

The parties are hereby advised that, pursuant to 28 United States Code, Section 636(b)(1)(C), written objections to the findings of fact, conclusions of law, and recommendation contained herein must be filed within ten (10) days of service of same. Failure to file objections to this Memorandum and Recommendation with the district court will preclude the parties from raising such objections on appeal. *Thomas v. Arn*, 474 U.S. 140 (1985), *reh'g denied*, 474 U.S. 1111 (1986); *United States v. Schronce*, 727 F.2d 91 (4th Cir.), *cert. denied*, 467 U.S. 1208 (1984).

This 5th day of January, 2005.

/s/ Dennis L. Howell
DENNIS L. HOWELL
UNITED STATES
MAGISTRATE JUDGE

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE WESTERN DISTRICT OF NORTH CAROLINA ASHEVILLE DIVISION

CIVIL NO. 1:04CV80

MARGARET T. WHITE, **Plaintiff,** **vs.** **SUN LIFE ASSURANCE COMPANY OF CANADA; GREER LABORATORIES, INC.; GREER LABORATORIES, INC. EMPLOYEE LONG TERM DISABILITY PLAN; PLAN ADMINISTRATOR OF THE GREER LABORATORIES, INC. LONG TERM DISABILITY PLAN,** **Defendants.**	**ORDER CLARIFYING AND AMENDING MEMORANDUM AND ORDER FILED AUGUST 11, 2005** (Filed Sept. 9, 2005)

THIS MATTER is before the Court on motion of Defendant Sun Life Assurance Company (Sun Life) for clarification of the Court's Memorandum and Order filed August 11, 2005.

The Plaintiff initially filed this action in the General Court of Justice, Superior Court Division of Burke County, North Carolina, and asserted against Sun Life state law claims for breach of contract, breach of duty of good faith and fair dealing, and unfair and deceptive trade practices, and "alternative" federal claims for benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plaintiff also asserted ERISA penalty claims against the other Defendants.

Sun Life moved to dismiss the state law claims as preempted by ERISA, and the ERISA claims as untimely. The Magistrate Judge issued a Memorandum and Recommendation on January 7, 2005, converting Sun Life's motion to dismiss to a motion for a judgment on the pleadings, and recommended the motion be allowed.

On January 20, 2005, the Plaintiff filed a timely objection, specifically objecting only to the recommendation that the Plaintiff's ERISA claim be dismissed as untimely. The Court, after a *de novo* review, denied Sun Life's motion for judgment on the pleadings as to Plaintiff's ERISA claims, finding that the claims were timely filed. The Plaintiff did not specifically object to the recommendation that her state law claims were preempted by ERISA and the Court's opinion did not address this part of the memorandum and recommendation. Sun Life now moves the Court for clarification as to whether or not the Magistrate Judge's recommendation that judgment be granted for Sun Life on Plaintiff's state claims on the grounds that they are preempted by ERISA was adopted by the Court.

As stated by the Court in the Memorandum and Order filed August 11, 2005, when reviewing an objection to a Magistrate Judge's memorandum and recommendation, the Court need only conduct a *de novo* review of those portions to which specific objections have been made. *Strawbridge v. Sugar Mountain Resort, Inc.*, 243 F.Supp.2d 472, 475 (W.D.N.C. 2003). Instead, the Court must "only satisfy itself that there is nor clear error on the face of the record in order to accept the recommendation." *Diamond v. Colonial Life*, 416 F.3d 310, 315 (4th Cir. 2005) (citing 28 U.S.C. § 636(b)(1)).

When the August 11, 2005, Memorandum and Order, was entered, the Court reviewed those portions of the Magistrate Judge's Memorandum and Recommendation to which no specific objection was made by the Plaintiff. The Court found no clear error on the face of the record, and therefore, the Magistrate Judge's recommendation that judgment be granted for Sun Life on Plaintiff's state law claims was accepted by the Court.

IT IS, THEREFORE, ORDERED that the Defendant Sun Life's motion for clarification is **ALLOWED**, and the Court's Memorandum and Order filed August 11, 2005, is hereby amended as follows,

IT IS, THEREFORE, ORDERED that Defendant Sun Life's motion for judgment on the pleadings is **ALLOWED IN PART AND DENIED IN PART**; the motion as to the Plaintiff's ERISA claims, on the grounds that said claims are untimely under a statute of limitations, is **DENIED**; the motion as to the Plaintiff's pendant state claims as being preempted by ERISA is **ALLOWED**, and the same are hereby **DISMISSED WITH PREJUDICE**.

Signed: September 9, 2005

/s/ Lacy H. Thornburg
Lacy H. Thornburg
United States District Judge

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

FILED
June 11, 2007

No. 06-1285
1:04-cv-00080

MARGARET T. WHITE

Plaintiff-Appellee

v.

SUN LIFE ASSURANCE COMPANY OF CANADA

Defendant-Appellant

and

GREER LABORATORIES, INCORPORATED;
GREER LABORATORIES, INCORPORATED
EMPLOYEE LONG TERM DISABILITY PLAN;
PLAN ADMINISTRATOR OF THE GREER
LABORATORIES, INCORPORATED LONG
TERM DISABILITY PLAN

Defendants

No. 06-1491
1:04-cv-00080

MARGARET T. WHITE

Plaintiff-Appellee

v.

SUN LIFE ASSURANCE COMPANY OF CANADA

Defendant-Appellant

and

GREER LABORATORIES, INCORPORATED;
GREER LABORATORIES, INCORPORATED
EMPLOYEE LONG TERM DISABILITY PLAN;
PLAN ADMINISTRATOR OF THE GREER
LABORATORIES, INCORPORATED LONG
TERM DISABILITY PLAN

Defendants

On Petition for Rehearing En Banc

The appellant's petition for rehearing en banc was submitted to this Court. As no member of this Court requested a poll on the petition for rehearing en banc,

IT IS ORDERED that the petition for rehearing en banc is denied.

Entered for a panel composed of Judge Wilkins, Judge Wilkinson, and District Judge Floyd.

For the Court,

/s/ Patricia S. Connor
CLERK

29 USCS § 1132

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . .

N.C. Gen. Stat. § 58-51-15 (2007)

§ 58-51-15. Accident and health policy provisions

(a) Required Provisions. – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($ 5,000) or more for any one sickness or injury; disability income policies affording benefits of one hundred dollars ($ 100.00) or more per month for not less than 12 months; and franchise policies. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,

2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are

covered under this policy (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." Except for the excepted benefits described in G.S. 58-68-25(b), credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30.

(3) A provision in the substance of the following language:

GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the record of the insurer written notice of its intention not to renew this

policy beyond the period for which the premium has been accepted.)

(4) A provision in the substance of the following language:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to

continue in force subject to its terms by the timely payment of premiums:

a. Until at least age 50 or,

b. In the case of a policy issued after age 44, for at least five years from its date of issue.)

(5) A provision in the substance of the following language:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's

right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

(6) A provision in the substance of the following language:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required.

(8) A provision in the substance of the following language:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any period payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision in the substance of the following language:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not

exceeding $ (insert an amount which shall not exceed three thousand dollars ($ 3,000)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services, may at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

(10) A provision in the substance of the following language:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision in the substance of the following language:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration

of three years after the time written proof of loss is required to be furnished.

(12) A provision in the substance of the following language:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(b) Other Provisions. – Except as provided in subsection (c) of this section, no such policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth below unless such provisions are in the substance of the words that appear in this section. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so

classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision in the substance of the following language:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision in the substance of the following language:

OTHER INSURANCE IN THIS INSURER: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for (insert type of coverage or coverages) in excess of $ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision in the substance of the following language:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other

coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase " EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provisions no third-party liability coverage shall be included as "other valid coverage.")

(5) A provision in the substance of the following language:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase " OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit

statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage.")

(6) A provision in the substance of the following language:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars ($ 200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

a. Until at least age 50 or,

b. In the case of a policy issued after age 44, for at least five years from its date of issue.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(7) A provision in the substance of the following language:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) Repealed by Session Laws 1955, c. 886, s. 1.

(9) A provision in the substance of the following language:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(10) A provision in the substance of the following language:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(11) Repealed by Session Laws 2001-334, s. 4.1, effective October 1, 2001.

(c) Inapplicable or Inconsistent Provisions. – If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) Order of Certain Policy Provisions. – The provisions which are the subject of subsections (a) and (b) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such

provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(e) Third-Party Ownership. – The word "insured," as used in Articles 50 through 55 of this Chapter shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(f) Requirements of Other Jurisdictions.

(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of Articles 50 through 55 of this Chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) Filing Procedure. – The Commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to Articles 50 through 55 of this Chapter as are necessary, proper or advisable to the administration of Articles 50 through 55 of this Chapter. This provision shall not

abridge any other authority granted the Commissioner by law.

(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2)b. of this section does not apply to policies issued to eligible individuals under G.S. 58-68-60.

Table of State Insurance Statutes

Ala. Code §§ 27-19-14, 27-20-5(7); Alaska Stat. § 21.54.030; Ariz. Rev. Stat. § 20-1355; Ark. Code Ann. §§ 23-85-116, 23-86-102(7); Cal. Ins. Code §1035011; Colo. Rev. Stat. § 10-16-202(12); Conn. Gen. Stat. § 38a-483(a)(11); Del. Code Ann. tit. 18, §§ 3315, 3541(7); D.C. Code Ann. §31-4712(c)(1)(K); Fla. Stat. § 627.616; Ga. Code Ann. § 33-29-3(b)(11); Haw. Rev. Stat. § 431:10A-105(11); Idaho Code §§ 41-2115, 41-2207(7); 215 Ill. Comp. Stat. 5/357.12; Ind. Code §§27-8-5-3(11), 27-8-5-15; Iowa Code §514A.3(1)(k); Kan. Stat. Ann. §40-2203(A)(11); Ky. Rev. Stat. Ann. §§ 304.17-150, 304.18-070(7); La. Rev. Stat. Ann. §22:213; Me. Rev. Stat. Ann. tit. 24-A, §2715; Md. Code Ann. Insurance § 15-217; Mass. Gen. Laws ch. 175 § 108(3)(a)(11); Mich. Comp. Laws § 500.3422; Minn. Stat. §62A.04(2)(11); Miss. Code Ann. §83-9-5(1)(k); Mo. Rev. Stat. §376.777(1)(11); Mont. Code Ann. §33-22-602(7); Neb. Rev. Stat. §44-710.03(11); Nev. Rev. Stat. §§ 689A.150, 689B.080; N.H. Rev. Stat. Ann. §415:6(I)(11); N.J. Stat. Ann. §17B:26-14; N.M. Stat. Ann. §59A-22-14; N.Y. Ins. Law §3216(d)(1)(K); N.C. Gen. Stat. §58-51-15(a)(11); N.D. Cent. Code §26.1-36-04; Ohio Rev. Code Ann. §3923.04(K); Okla. Stat. tit. 36, §4405(A)(11); Or. Rev. Stat. §743.441; 40 Pa. Cons. Stat. §§753(A)(11), 756.3; R.I. Gen. Laws §§ 27-18-3(a)(11), 27-34.2-7(b)(1)(x); S.C. Code Ann. §38-71-735(m); S.D. Codified Laws § 58-18-27; Tenn. Code Ann. §56-26-108(11); Tex. Ins. Code Ann. § 1251.116; Vt. Stat. Ann. tit. 8, §4065(11); Virginia Code Ann. §38.2-3503; Wash. Rev. Code §48.20.142; Wis. Stat. § 631.83; W. Va. Code § 33-15-4(k); Wyo. Stat. Ann. §§ 26-18-115, 26-19-107(a)(vii); P.R. Laws Ann. tit. 26, §1615; V.I. Code Ann. tit. 22, §865.